AFGHANISTAN HEALTH PORTFOLIO EVALUATION

February 2-23, 1992

Prepared for:

The Office of the AID Representative, Afghanistan

Prepared by:

Merrill M. Shutt, MD, MPH - Team Leader
University of North Dakota

Pamela A. Hunte, PhD
University of Connecticut

Jinny Sewell, MPH
ASIA/TR/HPN, AID/W

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LIST OF ACRONYMS AND ABBREVIATIONS

ACBAR	Agency Coordinating Body for Afghan Relief
AHSA	Area Health Services Administration (i.e., the SCNA, SSWA, HCCA AND HCPP area programs)
A.I.D.	Agency for International Development
AIG	Afghan Interim Government
ARI	Acute Respiratory Infection
AVICEN	Afghanistan Vaccination and Immunization Center
BHW	Basic Health Worker
CHW	Community Health Worker
CMC	Coordination of Medical Committees
CMCEP	Combined Mid-Level Continuing Education Program
EEC	European Economic Community
EPI	Expanded Program for Immunization
HCCA	Health Committee of Central Afghanistan
HCCP	Health Committee of Paktya and Paktyka
HI	Handicap International
HSSP	Health Sector Support Project
IMC	International Medical Corps
IPH	Institute of Public Health (MOPH)
IRC	International Rescue Committee
MCH	Maternal and Child Health
MCHO	Maternal and Child Health Officer
MCI	Mercy Corps International
MIS	Management Information Systems
MOPH	Ministry of Public Health
MSF	Medecins Sans Frontieres
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
O/AID/REP	Office of the AID Representative to Afghanistan
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PACD	Project Assistance Completion Date
PVO	Private Voluntary Organization
RHO	Rural Health Officer
SOW	Scope of Work
SCA	Swedish Committee for Afghanistan
SCNA	Supervisory Council of the North Area
SSWA	Health Committee of South and Southwest Area
TB	Tuberculosis
UNICEF	United Nations Children's Fund
UNOCA	Office of the Coordinator for United Nations Humanitarian and Economic Assistance to Afghanistan
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

I. Introduction

At the request of the AID Representative to Afghanistan (O/AID/REP), a three person external team evaluated the O/AID/REP health portfolio February 2 - 23, 1992.

Since 1986, O/AID/REP has supported health projects from Peshawar and Quetta whose beneficiaries live cross-border in Afghanistan. Current projects are the Health Sector Support Project (HSSP, 306-0203) administered by Management Sciences for Health (MSH) and the PVO Support Project (306-0203) administered by three private voluntary organizations (PVOs), International Medical Corps (IMC), Mercy Corps International (MCI) and the International Rescue Committee (IRC). The primary objectives of these training/service delivery activities are to develop and institutionalize the capabilities of Afghan authorities to operate effective health delivery systems and provide basic health care to Afghans living in rural areas of Afghanistan.

The evaluation is intended to assist the O/AID/REP target FY 1992 health funding obligations; prepare a health strategy for post-12/1992, the PACD of the HSSP; develop a plan for moving the program inside Afghanistan; and, outline needs to be addressed by a follow-on project. The following headings respond to the format of the Scope of Work and contain the major findings and recommendations.

II. Health Services Delivery

MCI and IMC, from Quetta and Peshawar respectively, directly manage the delivery of cross-border health services in clinics and hospitals in Afghanistan. MSH supports health services through the equivalent of Afghan counterpart organizations, the Ministry of Public Health of the Afghan Interim Government (MOPH/AIG), and Health Committees of four Area Health Service Administrations (AHSAs). The latter are the health components of rural regions within Afghanistan with sufficient military stability to permit a semblance of civil authority, including a limited tax base. Collectively, these projects represent the largest donor support of rural health delivery. In general, all of these implementing agencies initially provided exclusively curative care for war-related conditions, but in the past two years have given increasing

attention to primary health care. A long-standing ban on travel in Afghanistan by US citizens precludes direct observation and measurement of project outputs. From reports of monitoring systems maintained by the implementing organizations and from UN-agency reports, the Evaluation Team feels confident that health care delivery in rural Afghanistan is significantly better than in pre-war days, in large part due to these two projects.

RECOMMENDATIONS: O/AID/REP should:

- continue support of the currently-funded Cooperative Agreements (CAs).

- influence MCI, IMC and health activities of other donors to cooperate and coordinate with the MSH-supported Afghan quasi-civil structures (MOPH and AHSAs) or justify reasons for not doing so.

- discontinue support of three hospital/clinic facilities recently added to MSH's CA as soon as feasible. Their support is not consistent with the cross-border thrust of the rest of the portfolio.

III. Training

MSH, IMC and MCI all have supported significant training activities. Early efforts were directed to training non-physician providers - a three month-trained Basic Health Worker (BHW) by MSH through the MOPH Institute of Public Health, and 9/12 month-trained mid-level providers by IMC and MCI. Graduates were supplied, equipped and deployed throughout Afghanistan. The objective was to increase rural service delivery points as rapidly as possible. In the past two years, emphasis has been on quality rather than quantity of health providers. The O/AID/REP placed a cap on levels of personnel and facilities supported by the implementing agencies at levels existing September 30, 1991 (female providers and vaccination personnel were excluded from the cap), and asked the implementing agencies cooperatively to develop a course for refresher training of mid-level health workers. The Scope of Work asked about the quality of the resulting Combined Mid-level Continuing Education Program (CMCEP), its relevance to need in rural Afghanistan, and advice on its continuation.

Professional Afghan representatives of MSH, MCI, IMC, WHO and the Swedish Committee for Afghanistan (SCA, which supports a cross-border program about the size of MSH's) collaboratively developed a 4 week curriculum of extraordinary quality containing proper balances of the theoretic and the practical, primary health care and curative care, all carefully tailored for rural

health problems of Afghanistan. After graduation of the first class of 45 students from all 4 implementing agencies (MSH, IMC,MCI AND SCA), WHO certified the graduates as meeting its international Midlevel Health Workers Standards and Guidelines. MSH (through the MOPH's Institute of Public Health), MCI and IMC began the second (revised and improved) course February 23, 1992.

The Scope of Work also asked an assessment of training of laboratory technicians, and asked if it and other courses might be conducted collaboratively similar to the CMCEP. Team assessment was that the utilization of lab technicians in rural Afghanistan was so unclear that the Team could not recommend unequivocally continuation or cancellation of training of new laboratory technicians. The possibility of combined training of vaccinators for the Expanded Program for Immunization (EPI) was considered, but not recommended due to the overall lack of coordination of the EPI.

RECOMMENDATIONS: O/AID/REP should:

- continue and expand support of CMCEP refresher training in Pakistan, and encourage its earliest move into Afghanistan (All MSH training and refresher training of BHWs is now being conducted inside).

- support requests for refresher training for lab technicians, but consider requests for new training only on a case-by-case basis which includes justification of need.

- ask WHO and SCA to participate in an assessment of utilization and need for laboratory technicians.

- require the implementing agencies to provide a plan of coordination with each other, the SCA and the AHSAs prior to approving requests for EPI training.

IV. Maternal and Child Health (MCH) Programs

MCH activities in place and planned by O/AID/REP funded CAs have increased markedly during the past two years. The ability to reach females for MCH services has exceeded most predictions. The implementing agencies have devised various successful programs to attract female candidates for training for supervisory and service provider roles within the delivery system. Ways have been devised to permit male providers to provide more MCH services. Other programs utilize outreach to

improve the skills of indigenous traditional birth attendants and improve the health awareness of women through the use of trained laywoman volunteers. IRC has supported the Afghan Obstetric and Gynecology Hospital in Peshawar. When moveed into Afghanistan, it could serve as a decentralized training cum service site.

In addition to recommending continued O/Aid/Rep support of these and similar MCH initiatives, the Team recommended that after introduction of a planned fees-for-service program, O/AID/REP should support research to study whether the fees adversely affect access to health services by women and children.

V. Monitoring and Health Management Information Systems

US citizens have long been prohibited from travel within Afghanistan for political and security reasons. Obtaining reasonably valid information upon which program planning, implementation and evaluation can be conducted has been a challenging task. This has resulted in development of systems of monitoring by each of the O/AID/REP-funded implementing agencies designed to track commodity supply and resupply, confirm the presence and performance of deployed health personnel and facilities and the quality of that performance.

Because it is the implementing agency proving the most extensive cross-border assistance, and because that assistance is mediated through Afghan civil organizations rather than directly, MSH has developed the most elaborate field monitoring system. The system includes close monitoring by trained MSH Afghan teams of the provision of medical supplies and equipment from the warehouse to the MOPH in Peshawar and across the border to one of seven designated AHSA central supply depots within Afghanistan. The MOPH and AHSAs distribute to individual facilities. Other monitoring teams periodically visit each fixed facility and as many BHWs as possible, check medical supply, assess performance, and take a picture of personnel for later confirmation of identity in Peshawar. People in the community and the military commander are interviewed to assess satisfaction with performance. Additionally, each health worker keeps a patient log and treatment record (the "green-book") which is analyzed. Facilities and health workers are "cancelled" (no longer supported) when they can not be found or fail to meet standards. IMC and MCI have similar but less elaborate systems of monitoring. These are not fool-proof systems, but they provide as clear a picture of the field as is currently posssible. Some cross-validation of monitoring is afforded by sharing reports of similar WHO monitoring missions. Collection and analysis of data was impaired by a U.S. ban on cross-border assistance for security reasons from mid-July through December, 1991.

MSH has conducted comprehensive Health Resources Surveys of 22 of the 29 provinces, and has reported on 15 provinces. These surveys attempted to validate in each province all facilities listed in the MSH, WHO and ACBAR data bases by numbers, type of service and staff and correlation of equipment with facility staff. Useful information was obtained, but delays in data analysis decreased its timeliness. MSH also carried out Household Health Surveys in Wardak and Takhar Provinces to collect basic household data, determine major disease patterns by gender and age and household expenditures for health care. These surveys documented family willingness and capacity to pay for health care, particularly for medicines. Additional work in this area will be valuable to help determine user fees and other revenue generation based on capacity and willingness to pay.

RECOMMENDATIONS: O/AID/REP should:

- coordinate systematic review of all data sources by the MSH, MOPH, the AHSAs and supported PVOs to stimulate better facility/worker replacement, reduce duplication and strengthen the patient referral systems.

- require the implementing agencies to strengthen technical monitoring of worker competence.

VI. Institutionalization

Pyramidal health systems have been established world-wide to make maximum use of health resources. The relatively few specialized facilities and specialty-trained physicians are at apex of the pyramid, usually in the capital city. The pyramid widens as greater numbers of lesser-trained providers (mid-level health workers) provide less sophisticated services. The base of the pyramid is the community health worker (here, the BHW) with even less training who is able to provide most curative and preventive components of primary health care. Referral proceeds from the base upwards, and management and supervision from the apex downwards. The system emphasizes prevention in order to minimize the requirement for costly curative services.

Of all implementing agencies including those supported by other donors, only MSH, working through the MOPH and the AHSAs, is working to develop and install a pyramidal model, particularly in the regions managed by the ASHAs. Like other implementing agencies, it employs physicians and mid-level workers, and is the only implementing agency to have trained a Basic Health Worker for the community level foundation of the system. IMC, MCI and the Swedish Committee all directly manage large numbers of personnel and facilities, but these are free standing, not linked to any pyramidal system. These implementing agencies have not

linked with the MOPH or the AHSAs. They do not trust MOPH and ASHA capabilities or intentions, but were unable to provide the Team with any concrete reasons for their attitudes. The Team believes the MSH approach is the only currently viable method to begin development of rural, decentralized service systems upon which the future Afghan primary health care system can be built. MSH's current training of mid-level supervisory personnel should strengthen existing weak supervision.

The Scope of Work also asked for an assessment of strategies of the implementing agencies to move activities inside Afghanistan. Working through the AHSAs, MSH already has moved much of the training, medical logistics, field administration and EPI support inside to decentralized points. The MSH technical assistance team can transfer to Kabul rather quickly once that is permitted. The transfer of personnel of the MOPH, particularly the excellent staff of the Institute of Public Health, will depend on the terms of eventual settlement when the shape of the new government is determined. MCI is in final stages of completion of a teaching hospital south of Kandahar, and can transfer its teaching function soon thereafter. Expatriate staff and the administrative function then can move once it is permitted. The IMC did not share its plans for moving inside with the Evaluation Team.

The International Rescue Commission, historically a refugee relief organization, has indicated a high possibility of moving to Kabul post-settlement and continuing its operations through an indefinite transition to more stable conditions. IRC provides a useful mechanism to incorporate indigenous and non-US PVOs into the health system. It currently is supporting Pakistan-based operations of the Afghan Obstetrics and Gynecology Hospital, which when relocated in Nangarhar, has high future potential for a decentralized primary health care role for MCH. It also supports Handicap International which is training prosthetic technicians and providing prostheses for amputees. Amputations resulting from exploding mines may continue to plague Afghanistan for decades. Handicap International can transfer base operations to Afghanistan readily once post-settlement is established.

RECOMMENDATIONS: O/AID/REP should:

- continue to vigorously pursue establishment of pyramidal health care delivery systems through MSH, the other CAs and the SCA unless clear reasons to the contrary arise.

- continue to fund its current CA portfolio over this transition to facilitate program relocation to Afghanistan.

- obtain written plans for relocation from each of the CAs.

- continue to fund the Afghan Obstetrics and Gynecology Hospital once it moves inside because of its MCH training and service import.

- not provide future funding to Handicap International due to higher A.I.D. health priorities unless special or earmarked funds become available. There is no question that there is great need for such activities.

VII. Financial Affordability

The Scope of Work asked advice on how training facilities could be restructured or downsized to reduce costs without compromising quality. O/AID/REP already plans to close IMC's Thal training hospital by June, 1992, for cost savings. All MSH new and refresher training of BHWs has been moved inside. The cost implications of this are not clear, but decentralizing the training to regional areas certainly should have reduced transportation and dislocation costs. All indications are that BHW training in these decentralized areas has resulted in higher quality, more relevant training for the BHWs.

Determining absolute and relative training costs for the different implementing agencies is complicated by the lack of comparable methods of cost determination. The mid-level training of mid-level personnel by IMC and MCI currently is being done in Pakistan in teaching hospitals with relatively fixed annual costs necessary to provide largely curative services to refugees. While important, these curative services are not contributing to development of pyramidal health services within Afghanistan. Until mid-1988, all training done by the MOPH Institute of Public Health was conducted in refugee camps or in hospitals or clinics not funded by O/AID/REP. The use of these facilities was certainly cheaper than funding the clinical facilities. This recently has changed with the addition of O/AID/REP support, through MSH, for three clinical facilities, part of whose function apparently will be training. One obvious cost cutting measure would be a decrease in levels of support for training facilities in Pakistan which are not contributing to institutional development and development of pyramidal health services within Afghanistan. The costs of support could be decreased by funding only those portions of the training hospitals most important for training, or by using clinical facilities funded by others. Transfer of the training functions inside of Afghanistan might not result in cost savings, but would contribute to institutional development and direct provision of services to rural Afghans.

High recurrent costs of health services can not be borne indefinitely by O/AID/REP. As a move towards cost-cutting and revenue-generating, O/AID/REP is requiring all implementing

agencies which it supports to cut health personnel costs (except for administrative and preventive primary health care personnel), 25 percent initially and an additional 25 percent 6 months later. Simultaneously, the health facilities are to initiate revenue generation programs to make up for the salary gap, probably through the establishment of fee-for-service or creation of a revolving drug fund from the sales of medicines. MSH will begin the process in April, 1992, and the other implementing agencies a few months thereafter. There is predictable opposition to this move. The very few government health services provided in pre-war Afghanistan were free. Some argue that cost-sharing should be taken only in tandem with all other donors, e.g., the SCA. The MOPH and AHSAs see the eventual requirement for such measures, but feel the timing is wrong. While there is some justification for each argument and risks do exist, the Evaluation Team feels that O/AID/REP's committment to these measures should continue and the results assessed.

Another cost-cutting measure has been combined procurement of drugs by the implementing agencies. This followed a thorough review by MSH of drugs it supplied, elimination of some and reductions of amounts provided of other line items. IMC and MCI drugs were standardized with those provided by MSH, and procurement for all 3 implementing agencies is now coordinated by MSH. Cost savings resulting from this combined procurement have been impressive. In addition to cost savings, a higher degree of quality control has resulted from this process because of MSH's higher quality control measures than those of MCI and IMC. Similar cost savings might result from an MSH review of its provision of medical supplies and equipment and appropriate adjustments made.

An analysis of salaries paid to health workers in similar categories by the O/AID/REP-funded implementing agencies shows a considerable range. Narrowing of these differences will occur after the salary reductions, but it would be desirable if it were possible to standardize salary levels of all implementing agencies, including SCA, whose levels are generally below O/AID/REP-funded levels. Standardization would minimize job-hopping and reduce destructive competition among the agencies for specific categories of personnel.

RECOMMENDATIONS: O/AID/REP should:

- support transfer of currently funded training facilities from Pakistan to inside Afghanistan as soon as security conditions permit and no later than 120 days after establishment of the US Embassy in Kabul.

- require comparable computations of training costs from MSH, MCI and IMC under existing training arrangements and under possible cost-saving arrangements, such as use of other clinical settings, or with O/AID/REP funding only operating costs for specific units of the teaching facility.

- require full participation in combined drug and equipment procurement, presentation of acceptable cost containment plans and a standardized salary scale range as conditions for renewal of CAs.

- conduct operations research after implementation of cost-sharing on client ability and willingness to pay for services on a regular basis.

MSH should: do a review of its supplies and equipment lists by no later than August 30, 1992 (similar to its review of drugs) to identify possible reductions in line items and amounts supplied.

VIII. Program Management

Questions posed by the Scope of Work concerned advisability of merging the two projects into a single management unit, the size and appropriate professional qualifications of expatriate staff of implementing agencies and the Office of Health, and the progress and problems associated with "Afghanization".

The Team concluded that it was preferable to not merge the two projects now. The advantages would be few. Considerations for not now merging include: 1) the operating mechanisms which are working satisfactorily might be disrupted at a critical period during transition and limit current flexibility in timing the move into Afghanistan; 2) backlash against an implementing agency in either project, for whatever reason, might be less likely to damage the entire portfolio than could be the case if the implementing agencies were part of a single project; and, 3) it seems prudent to see how successful each of the implementing agencies is in dealing with the volatile issue of cost-sharing prior to new project design.

By June, 1992, the numbers of expatriate staff of the PVOs appear that they will be as low as they can be to carry on the tasks of their CAs and maintain accountability. MSH's apparently high level of expatriates (nine) does not seem excessive given its CA responsibilities and considering its developmental advisory, not directly operational, role. If funding or personnel levels absolutely require reductions, the Team made

suggestions where resident expatriate staff might be replaced by periodic consultants. The size of the O/AID/REP Health Office (one direct hire and 2 personal services contractors) is adequate currently, but will need reassessment once a move is made to Kabul.

Progress towards "Afghanization" is satisfactory in spite of the relative paucity of technically trained Afghans, lack of opportunities for Afghans to get quality technical training and the fact that even a well qualified Afghan may not be as effective in a given position as a "neutral" expatriate given conflicts arising from claims on his loyalty by his tribe, ethnic group, religious faction, language, political party and local military commander.

RECOMMENDATIONS: O/AID/REP should:

- not consider merging the health portfolio until the post-settlement situation becomes clear.

- require health expertise and previous overseas project experience for the Key Personnel of its CAs.

I. BACKGROUND

A. Introduction

Since 1986, the Office of the AID Representative, Afghanistan (O/AID/REP) has supported health projects from Peshawar and Quetta whose beneficiaries lived cross-border in Afghanistan. Current projects are the Health Sector Support Project (HSSP, 306-0203) administered by Management Sciences for Health (MSH) and the PVO Support Project (306-0203) administered by three private voluntary organizations (PVOs), International Medical Corps (IMC), Mercy Corps International (MCI) and the International Rescue Committee (IRC). The primary objective of these training and service delivery activities is to develop and institutionalize the capabilities of Afghan authorities to operate effective health delivery systems and provide basic health care to Afghans living in rural resistance-held areas of Afghanistan. A secondary benefit has been provision of health and medical services to Afghan refugees in Pakistan resulting from training activities. The predecessor project to the PVO Support Project was evaluated in November, 1989, and the HSSP was evaluated in February, 1990.

B. Scope of Work

The results of the evaluation are intended to assist the O/AID/REP target FY 1992 health funding obligations; prepare a health strategy for post-12/92, the PACD of the HSSP; and, outline needs to be addressed by a follow-on project. To report its results, the Evaluation Team was specifically directed to follow a format which responded to detailed questions in the Statement of Work. The detailed Statement of Work appears as Appendix A.

C. Methodology

The Evaluation Team was constituted of two external consultants (Shutt, Hunte) provided through an Indefinite Quantity Contract with Nathan Associates, Inc. and a representative of A.I.D. Washington's Asia/TR/HPN (Sewell). Prior to arrival in country, the Team members were provided briefing documents for review. The Team (minus the delayed Team Leader) assembled in Islamabad and were briefed by the AID/REP and his staff on February 2, 1992, and proceeded to Peshawar that evening. The Team Leader received an abbreviated briefing upon arrival in Islamabad February 3, and joined the other members that afternoon in Peshawar The Team embarked on a series of pre-arranged meetings with Afghan health officials, all the partners to the Cooperative Agreements, other donors and relevant

organizations/agencies. The Team then agreed upon a division of labor and made individual appointments in and around Peshawar for information gathering. Shutt later visited MCI in Quetta. On nearly a daily basis the Team members met for information sharing and planning, and touched base periodically with appropriate O/AID/REP staff. A draft report was prepared in Peshawar. On February 19 the Team was debriefed in Islamabad by the Deputy AID Representative and staff, and based on that debriefing, editing and additions were begun by the full Team on February 20 and the report completed February 23. A list of people contacted appears as Appendix B.

II. Health Services Delivery

> "Assess the relative strengths and weaknesses of the regional health delivery systems in Shura-e-Nazar, South and Southwest, Paktya/Paktyka and the Hazarazat; the AIG Health Delivery Systems in various areas of Afghanistan; and the NGO (MCI and IMC) health delivery systems throughout Afghanistan, and determine whether the design and implementation of these efforts is suitable to sustainable delivery of health services to the rural Afghan population. Ascertain the possibility and method(s) of integrating these three systems (regional, AIG/MOPH, and the NGO) under current conditions, and with a possible future central Ministry of Health based in Kabul."

The complexity of establishing a health program cross-border without a recognized government nor numerous local implementing organizations to readily work with has necessitated an evolving program strategy by the O/AID/REP.

The Health Services Support Project was the first designed and funded by the O/AID/REP. In the absence of recognized counterpart implementing organizations, the O/AID/Rep under the HSSP negotiated a three year Cooperative Agreement in 1986 with Management Sciences for Health (MSH) for $15.7 million, which was later amended in 1988 and increased to $60 million and extended to December 31, 1992. Under the Private Voluntary Organization Support Project, the O/AID/Rep has supported yearly agreements with the International Rescue Committee (IRC), the International Medical Corps (IMC) and Mercy Corps International (MCI) for health care activities. These agreements began at different times since 1986 and are negotiated and renewed on an annual basis. They currently are all Cooperating Agreements. The funding levels usually range from $1 to $2.5 million a year to support mostly curative care

Under the Health Services Support Project, MSH worked with the Alliance Health Committee, and subsequently the Ministry of Public Health of the Afghan Interim Government which was established upon withdrawal of the Soviet troops from Afghanistan. In tandem, MSH also works with the Area Health Service Administrations (AHSAs) in four geographic areas in Afghanistan: North (Shura-e-Nazar), South and Southwest, Paktya/Paktyka (West) and the Hazarazat (central).

Of the PVOs, the types of programs fall into two areas. IRC provides small subgrants to Peshawar-based and Quetta-based organizations. IMC and MCI run primarily curative care facilities with some PHC programs in Afghanistan and training facilities in Pakistan.

A. Health Services Support Project

MSH began development of its health assistance program for Afghanistan in late 1986 through the O/AID/Rep-funded Health Services Support Project. As it moves into its sixth year of implementation, this $60 million Project has supported the development of a rural/community based health care system in Afghanistan. Since very little existed in the way of rural health care services prior to the war, there has been significant progress in spite of the on-going turmoil within Afghanistan.

MSH presently works with two entities, the Ministry of Public Health of the Afghan Interim Government (MOPH/AIG) based in Peshawar and health committees of the four AHSAs mentioned above. While these health committees have small liaison offices in Peshawar, the main organizations are based inside Afghanistan to oversee implementation of rural based health care services.

MSH recognized the need to support decentralized health delivery efforts in order to increase the number of services throughout the country and groups able to develop and sustain programs. Given the MOPH/AIG's limited efforts and ability to oversee field programs within Afghanistan, the four AHSAs maintain a field oversight advantage by their presence and leadership within Afghanistan.

1. Ministry of Public Health/AIG

Although it remains unclear as to the future of the MOPH/AIG after a settlement, MSH has made good investments in staff development, planning and training capacity through its range of technical assistance to the MOPH Institute of Public Health

(IPH), the Preventive Medicine Department and the Maternal and Child Health Department. Many of the high quality professionals in these offices of the MOPH may have a place in further development of the health care system in Afghanistan when a settlement is reached and a new government established.

The relative strength of the MOPH program has been its emphasis on training of Basic Health Workers (BHWs) and refresher training for all levels over the last several years; however, the MOPH lacks a strong in-country linkage for on-going program and technical supervision of workers deployed to rural facilities within Afghanistan. At present the MOPH/AIG supports one Primary Health Care (PHC) hospital, 60 Comprehensive and Basic Health Centers, 13 Maternal Child Health (MCH) facilities and 981 Basic Health Posts.

The MOPH/AIG has recognized the importance of a rural based PHC system within Afghanistan to provide basic services for common health care problems. MSH's work with the MOPH/AIG has been instrumental in structuring the training and service delivery programs for PHC to establish a viable preventive program aimed at reducing the incidence of infant, child and maternal morbidity and mortality. Key MOPH/AIG staff have also participated in short-term U.S. training at Boston University in planning and management of PHC programs. This participant training has greatly expanded both the understanding and commitment of the MOPH/AIG staff to the development of PHC in Afghanistan.

Beginning January 1, 1992, support for three tertiary hospital facilities run by the MOPH/AIG in Peshawar was picked up by the HSSP under the MSH budget. These facilities cost over $1 million annually to operate and do not function as an integral part of the O/AID/REP health sector strategy to expand rural health services within Afghanistan. For both O/AID/REP and MSH staff there has been a considerable management burden caused by the hospitals that detracts from other program components of greater priority. From a management, program and funding perspective, and from the Team's technical perspective, hospital-based health care provided through facilities in Pakistan is not consistent with the cross-border emphasis of the overall O/AID/REP portfolio. Although it's possible that the hospitals may serve a limited training function for the MOPH/AIG, this has limited potential for integration into a future long-term health sector assistance program within Afghanistan.

The MOPH/AIG and its successor organization in a newly created government in Kabul should focus its attention on policy making, planning, manpower development and training, and limited

health care delivery in areas such as urban health and special programs for TB and malaria. An important new MOPH role would be planning and coordination for quality assurance and standardization of training and care among decentralized delivery systems such as those presently carried out by the AHSAs.

2. Area Health Service Administrations

Because of the political uncertainties and realities relative to the establishment of a new Kabul Government, MSH has supported the development of decentralized health care services through the AHSAs. These programs are managed by four independent health committees, the Health Committee of Central Afghanistan (HCCA), the Health Committee of Paktya and Paktyka (HCPP), the Supervisory Council of the North Area Health Committee (SCNA), and the Health Committee of South and Southwest Area (SSWA). These four committees are at varying stages of development. SCNA, formed prior to association with MSH in mid-1987, is the oldest and best organized committee. MSH also began working with SSWA in 1987, with HCCA at the end of 1989 and with HCPP in 1991. All four committees have liaison offices whose committee staff in Peshawar meet on a regular basis to coordinate activities and work on common issues. Liaison staff coordinate with MSH on program initiatives and serve as a link back to the health committees in their cross-border area and oversee transport of supplies and equipment and salaries to destinations within their area. MSH has worked extensively with the AHSAs, and they are strong proponents of PHC. In addition they are also an important link for training and development of recent program initiatives such as EPI, MCH and development of fee-for-service.

The Area committees within Afghanistan have administrative and technical oversight of the health programs in their geographic areas. Within these four areas the HSSP supports one referral hospital, 15 PHC hospitals with up to 20 beds, 98 Comprehensive and Basic Health Centers, 17 MCH facilities and 380 Basic Health Posts. The four Health Committees are responsible for all workers and facilities, provide supplies on a regular basis, disburse salaries to workers and provide technical oversight, supervision and training. Although the IPH initially trained all new workers, the AHSAs have taken up the training of all BHWs through the establishment of regional training facilities.

The AHSAs also have the capacity to create a local tax base from which to support programs. While the MOPH may be reconfigured under a new government, the AHSAs are likely to continue to have some local autonomy due to popular support and established leadership under strong Mujahiddin commanders All AHSAs have agreed to work as decentralized PHC programs in cooperation with the future Kabul MOPH

B. Private Voluntary Support Project

1. International Rescue Committee

IRC has served as a funding conduit for the O/AID/Rep to provide subgrants to Peshawar-based (and more recently Quetta-based) health organizations. Over the last few years it has provided several grants to local Afghan institutions. The active ones at present are the Afghan Psychiatric Center, the Afghan OB/GYN Hospital for Women in Peshawar and Handicap International (HI) in Quetta. Of these, the Psychiatric Center has recently been evaluated and probably will not be refunded due to a variety of problems, including the loss of its only professional psychiatrist on staff. The OB/GYN Hospital is currently under evaluation and HI will be evaluated in the future.

IRC has $800,000 remaining in its current Cooperative Agreement, and is reviewing new grant applications. While IRC has in the past been primarily a funding conduit, it has expressed a need to provide a range of technical assistance to future subgrantees in order to strengthen programs. This approach seems justifiable and may be very useful to a Kabul based A.I.D. program in the future. Through IRC, A.I.D. could tap into both technical oversight and funding capacity to local organizations serving people in Afghanistan.

Although IRC has been primarily a refugee organization, its Board of Directors sees a role to move into Afghanistan after a settlement and provide services during a transition period and as the situation normalizes. It has expressed a need to be more involved in programs funded by O/AID/Rep in program selection, technical assistance, financial management, and other appropriate support functions. In other words, it does not want to be just a banker. IRC, with its professional skills and interest in continuing assistance inside Afghanistan, could play an important role in funding and building local capacity to implement health programs.

2. International Medical Corps

IMC began eight years ago as a medical emergency relief organization to treat war related injuries inside Afghanistan. It operates 59 facilities inside Afghanistan: 8 small hospitals and 51 clinics. In addition, it also runs one hospital and facilities for health worker training in Peshawar and Thal. IMC's intermediate and long-range goal is to increase the number, quality and scope of its in-country medical facilities. IMC wishes to train 37 mid-level workers to work in 22 existing sites that are currently understaffed

Its medical facilities are staffed by medical doctors, mid-level workers, lab and x-ray technicians and pharmacists. Although it began and continues to be a curative care operation, it has changed from a war-related treatment focus to general treatment. Along with curative care, it also has an interest in the Expanded Program for Immunization (EPI), MCH and control of diarrheal diseases. It employs 45 vaccinators who work in two or three person outreach teams to carry out immunization programs for children and women. If funding permits it will institute a diarrheal disease control program in all of its facilities in the next year. Training facilities in Thal and Peshawar are participating in the Combined Mid-level Continuing Education Program (CMCEP).

IMC has expressed several reservations regarding an O/AID/Rep mandate to reduce salaries and initiate user fees in facilities of all implementing agencies beginning July 1, 1992. IMC feels that this will invite corruption and misuse of funds, delay treatment until illness is more severe and treatment is more expensive and will tend to further reduce access of women and children to services. However, it has not developed alternative options to deal with the reality of shrinking donor resources.

While IMC has a markedly negative view towards the four AHSA committees, it admittedly has not made any attempts to coordinate with these groups to date. It tends to see its operation as independent of other health initiatives and in general expresses a poor attitude towards coordination.

3. Mercy Corps International

MCI is located in Quetta where it operates one hospital, one MCH clinic and one training facility. Its cross-border activities began in 1986, and over the years its facilities have increased to 44 clinics (39 supported by O/AID/REP) in Afghanistan run through coordination with local commanders.

These clinics deliver health services to the people of South-central Afghanistan. Of its 39 O/AID/REP-supported clinics, 36 are in areas that are not covered by any AHSA. MCI has started discussions with the health committees of SSWA and HCCA on the possibility of linking programs. Although initially curative oriented, MCI is attempting to incorporate MCH and EPI services to broaden into critical preventive health care areas. In order to bring this about, MCI plans to carry out female mid-level training, MCH assistant training and female community health promoter program training. MCI also operates one site of CMCEP training.

O/AID/Rep has funded a reasonable mix of preventive/basic health care and curative care in the rural areas through the programs supported by the MOPH/AIG, AHSAs and the PVOs. Together, they all support a basic rural health care delivery system inside Afghanistan which essentially did not exist prior to the war. However, there are areas of program coordination that can be realized for efficiency and cost savings.

RECOMMENDATIONS

- The O/AID/Rep should continue its support for both basic health services and curative care through those CAs presently funded by the HSSP and the PVO Support Project

- The O/AID/Rep should continue to strengthen the decentralized system of health care through the ASHAs as these organizations are likely to have continued presence even with a change of government in Kabul.

- MSH should continue support for the MOPH/AIG in PHC to emphasize its role in national policy making, planning and coordination, manpower development and training while de-emphasizing its role in service delivery (letting the AHSAs take over facilities/workers) given its lack of supervisory oversight capacity inside Afghanistan.

- O/AID/Rep should structure all Cooperative Agreements to mandate:

    a. Standardization of training and certification of all levels of workers and periodic worker skill recertification. MSH should explore WHO certification of BHWs to help insure them a post-settlement role in the health delivery system.

    b. Coordination with other CAs on facility and worker placement, services scheduling (e.g., immunization targets and scheduling) and establishing of cross-organizational referral networks.

- O/AID/REP should discontinue support of the three MOPH/AIG Peshawar based hospitals as soon as it is feasible.

III. Training

A. Combined Mid-Level Continuing Education Program

"Judge the quality and costs of the Combined Mid-Level Continuing Education Program at Al Jehad Hospital (Quetta) and Thal and advise on its continuation, location and structure. Determine whether the content of training programs is relevant to priority needs inside Afghanistan".

The CMCEP is a combined effort by the major donors supporting cross-border health delivery programs (O/AID/REP and the Swedish Committee for Afghanistan) to provide high quality, standardized refresher training to mid-levels employed by MSH (for the MOPH or the AHSA), MCI, IMC and the SCA, no matter their source of training in this 16 week course.

The course was developed after long recognition of the varying quality of training which mid-levels had received, their lack of opportunities for quality refresher training, and agreement to reorient the mid-levels from pure war-related curative care to primary health care. A core committee was constituted from Afghan professionals among the employing groups to which was added an Afghan member from WHO. From the beginning, the intent was to develop a course which if satisfactorily completed would meet international criteria certified by WHO as meeting its Mid-level Health Workers Standards and Guidelines.

In 1991, a pilot course was conducted in Quetta (MCI) for Pushto speakers and one in Thal (IMC) in Farsi. Both facilities took students from any employer. After evaluation and examination, WHO certified forty-five graduates. Not only should this certified completion assure improved technical competence in the graduates, but it should legitimize their participation in a future government health system.

After evaluation of the pilot courses, there was extensive revision of the curriculum to make it even more attentive to need. Instruction materials were reviewed word for word to eliminate translation mistakes and correct technical deficiencies. Corrections were made in both Pushto and Farsi versions. The O/AID/REP, who had placed a cap on numbers of new workers trained to replacement levels, had encouraged development of the courses by the Institute of Public Health, MCI at Quetta

and IMC at Nasir Bagh (near Peshawar) and Thal during the remainder of the current Cooperative Agreements. Selection of the candidates for the second course occurred in mid-February, 1992, and the next class began February 23, 1992. Classes of 20-24 students each will be conducted in Pushto at the IPH and Quetta, and in Farsi at Thal and Nasir Bagh.

The Evaluation Team reviewed the course outline and found it excellent in design and in the time allocated to various topics. The curriculum is exceedingly strong in primary health care topics, including principals of sanitation, diagnosis and treatment of common conditions, health education, endemic diseases, control of diarrheal diseases (including use of oral rehydration solution), nutrition assessment, growth and development, breast feeding and weaning, women's care, childhood diseases, expanded program for immunization and vector control. There is lesser but strong clinical content appropriate for the conditions in rural Afghanistan. The course is designed to be 60 per cent practical, 40 per cent theoretical.

There is unquestioned need for the course based on the widely varying quality of mid-levels as reflected in the pre-qualifying exams for admission to the second course, and because of the large numbers of mid-levels practicing in Afghanistan. MSH, IMC, MCI and SCA employ well over 1000 mid-levels among them, a good portion of whom would benefit from the training and be in a better position to qualify for a post-settlement position within the established health system.

The Thal facility of IMC has a good reputation for training. Previously funded under Freedom Medicine (now departed), it was provided one-year funding by O/AID/REP under the IMC Cooperative Agreement. The O/AID/REP has decided to not renew funding July 1, 1992, as a cost saving matter. That leaves three identified training sites in Pakistan to continue this training. The objective should be to transfer this training inside Afghanistan as soon as possible. After the four-month course beginning in February, 1992, is evaluated, O/AID/REP may want to discuss with the training entities whether they can begin cross-border classes before a settlement.

The comprehensive CMCEP is a solid move toward quality health care in Afghanistan and is highly relevant to the health needs of Afghanistan. The Team was unable to derive specific financial information which would provide comparability among the sites. Because CMCEP represents the major O/AID/REP-funded training activity at Quetta and Nasir Bagh and is being conducted in AID/REP-funded curative facilities with relatively fixed annual costs, the unit per capita training costs at these sites

are relatively high compared to earlier training conducted by the Institute of Public Health in non-O/AID/REP-funded facilities. As long as the training occurs inside Pakistan, the major approach to reducing per capita costs would be to train as many mid-levels per year at each of the three facilities.

RECOMMENDATIONS

- O/AID/REP should continue to support CMCEP refresher training in three training sites in Pakistan, and the possibility of moving those training sites cross-border should be considered (for as early as June, 1992, conditions permitting).

- MCI, IMC and MSH should be encouraged to increase numbers of CMCEP graduates by considering modest increases in the students admitted to each session and by decreasing the interval between sessions.

B. Laboratory Technician Training

"Assess the laboratory tech training of the AID/REP-funded entities and advise on standardization and integration of efforts."

MSH, IMC and MCI at varying times have conducted courses for laboratory technicians, or more correctly field microscopists. The MCI training was a three month course following its basic midlevel training for a portion of each graduating class to give them some specialty training.

MSH, IMC, MSF Belgium and a French PVO are conducting a four month standardized course derived from a WHO curriculum. Students have usually had 9th or 10th grade educations and need not necessarily have had any other medical background. They are taught very basic lab techniques appropriate for diagnosis of TB and malaria, "dip-stick" and microscopic urinalysis, stool analysis for ova and parasites and hemoglobin determination. Successful graduates of the courses can be indirectly certified by WHO through MSF Belgium. MSF Belgium also has a course for training a more qualified lab technician. To date, no refresher training has been established, but IMC is requesting funds for a two-week refresher course.

It is difficult to assess how useful the field microscopist training is. If the skills of the deployed field microscopists were maintained by frequent use and supervision, the microscopists could provide a very useful service, particularly in TB, malaria and confirmation of anemias It is doubtful that they are utilized much, if at all, in facilities which have no

physicians, although ideally mid-levels also should be capable of requesting laboratory assistance. Rarely are they supervised for quality control Their use is dependant on a reliable electricity source and this is lacking in a great many facilities. No systematic assessment of need has been conducted. In a survey of health facilities in 15 provinces, MSH found 104 facilities with physicians, only 33 of which had any lab capability. This indicates a potential need for more technicians or for reassignment of existing technicians.

MSH has trained eighteen field microscopists. Additionally, it has trained three "master trainers" which are intended to go cross-border and assess how labs are working.

IMC has deployed field microscopists to 80 per cent of its existing facilities and has requested approval to train eleven more so that all its facilities are served. O/AID/REP has indicated it will support adding these 11 personnel only if other operating costs of the clinics are reduced so that the addition of these personnel does not increase total operating costs.

Until there is additional information available on cross-border utilization of laboratory facilities and of field microscopists, it is not possible to recommend confidently continuation or cancellation of training additional technicians.

RECOMMENDATIONS

- Requests for O/AID/REP support for training of new field microscopists should be considered on a case-by-case basis and should include documentation of the location of the facility to which the microscopist will be assigned and of all other health facilities within a 5 kilometer radius, qualifications of its staff, source and reliability of electricity and justification of need.

- Refresher training such as that proposed by IMC should be supported for all CAs using a collaborative model similar to the CMCEP. SCA and WHO should be invited to participate.

- O/AID/REP should ask WHO and SCA to participate in a broad-based representative assessment of utilization and need for field microscopists. MSH's proposed survey by its "master trainers" might serve as a foundation for such a joint effort.

C. Opportunities for Combined Training

"As possible, look at other training efforts which may be combined."

Future training for the Expanded Program for Immunization (EPI) is an area where joint or combined training might be considered but cannot be recommended at this time. Coordination of EPI worldwide has been a joint UNICEF-WHO responsibility, but coordination of cross-border immunization has been disappointing. A major problem has been poor internal coordination by both UN organizations between Afghanistan and Pakistan, and within Pakistan among Islamabad, Peshawar and Quetta. Additionally, AVICEN (Afghanistan Vaccination and Immunization Center, an EEC-funded French NGO) has been given a central vaccine logistics and training role by UNICEF and it has resisted implementation of the standard UNICEF-WHO EPI program. It has, for instance, insisted on immunizing all children under five instead of limiting it to two year olds initially and to one year olds later, as is standard. The costs of its approach are prohibitive. Its otherwise excellent training course teaches vaccination under five. This has caused confusion and discord on the part of other implementing agencies. UNICEF and WHO have been struggling to establish a unified approach and training curriculum for cross-border EPI, but it likely will not be implemented until at least June, 1992.

The EPI program is a combination of mobile, outreach and fixed (clinic-based only) approaches, certainly appropriate currently for Afghanistan. IMC and MSH are following a curriculum for vaccinators based on WHO-UNICEF worldwide standards and presumable very close to the one WHO-UNICEF will ultimately certify for cross-border immunization. MCI has been unable to start an EPI program because UNICEF could not supply vaccine. O/AID/REP is making a one-time vaccine procurement which should permit MCI to start a clinic-based EPI program in July.. MCI is in discussion with AVICEN attempting to arrange training through that body.

Until there is a comprehensive and coordinated EPI program in which all major implementing agencies participate, we do not recommend attempts to develop combined training of vaccinators. Such might be later considered, but it might make more sense to develop a single training site for all vaccinators, irrespective of implementing agency.

A much more immediate problem is the absolute lack of EPI coordination among implementing agencies, including coordination even among the CAs funded by O/AID/REP. The duplication, gaps in coverage and waste resulting from this is tragic and largely inexcusable

RECOMMENDATIONS

- The O/AID/REP, prior to approval of EPI training by its funded CAs, should require an acceptable detailed plan for coordinating each CA's EPI program with that of other CAs, SCA, AVICEN and the AHSAs. The plans will include a description of the EPI program and the geographic population it intends to cover. If the program is fixed (clinic-based only) or outreach, it should assure that these activities are coordinated with any mobile teams operating in the same ares. O/AID/REP should request UNICEF comment on each plan.

D. Basic Health Worker Training Inside Afghanistan

"What have been the quantitative implications of conducting Basic Health Worker training inside Afghanistan?"

In July, 1988, training of Basic Health Workers began inside Afghanistan in the AHSAs, the first being by the Supervisory Council of the North Area (SCNA). Subsequently, all new and refresher training has been moved from Peshawar to 6 cross-border sites (including Miram Shah, which is on the border). Five are AHSA sites and one a MOPH site.

Although no comprehensive evaluation of the cross-border training has been attempted, it is the strong impression of the IPH, the AHSAs and MSH that such training is superior to that which had been conducted earlier in Peshawar. These impressions are based on: 1) the fact that students trained near home and their trainers are much more familiar with local health conditions and emphasize material appropriate for that area; 2) since 1988, the basic standard curriculum has been extensively revised and updated along PHC lines, and is greatly superior to the curriculum given earlier; and 3) MSH has had the in-country training assessed on-site by a seasoned Afghan trainer on its staff, and it is his professional opinion that the current training and refresher training are superior and have much greater relevance to need than did earlier training.

IV. MATERNAL AND CHILD HEALTH (MCH) PROGRAMS

This discussion combines two interrelated sections of the Scope of Work which pertain to both the recipients and the providers of MCH:

> "Assess whether the various health delivery systems have made satisfactory progress in increasing the numbers of women and children served, and make recommendations for future improvement."
>
> "Make recommendations for increasing the numbers of female trainees/trainers at the basic and mid-level health worker levels."

MCH programs are often difficult in the Afghan socio-cultural context where many women are affected by various degrees of seclusion especially in this period of political insecurity. The present atmosphere on both sides of the border is more conducive than in recent years, however, and positive action in this high-priority area has recently been undertaken.

O/AID/REP realizes the importance of MCH in the Afghan context, and there are presently no specific financial limitations on this sector of health care delivery. Similarly, there are no limitations placed upon recruitment or training of female health personnel.

A basic constraint is in the lack of female health personnel. Some women may attend health facilities with male staff for general health complaints and/or bring their children for treatment; for example, the recent Provincial Health Resources Survey in Afghanistan (MSH 1991) indicates that the ratio of women patients per facility frequently ranges from 20-30%. Many women do not have permission to attend facilities with only male personnel, however, and especially for perinatal care, intensive health education and outreach female staff is essential.

A. Management Sciences For Health

The leader in MCH among the O/AID/REP funded CAs is MSH, whose staff includes an expatriate Advisor in Women's Health and Education. She works closely with the MCH Department of the MOPH/AIG, which was established in 1989, and with the four regional committees of the AHSAs. All of these Afghan groups realize the importance of MCH and, in spite of its political sensitivity with respect to the status of women, they are seemingly optimistic and committed to future expansion of such services inside Afghanistan

At present there is a total of 30 active MCH Centers inside Afghanistan supported by MSH (MOPH/13; SCNA/8, HCCA/6; SSWA/3; HCPP/0). These are scattered throughout the country, with heavier concentration in the eastern and northern regions Each of these facilities contains at least one female staff member, with a total of more than 50 females presently employed. These women are from the areas in which the health facilities are located

Of the 30 centers, 9 are MCH Posts where a female mid-level health worker functions independently but in coordination with a previously existing health center, and 21 are MCH Clinics where at least one nurse-midwife or female doctor is on the staff; clinics provide preventive and curative services for women and children, including pre/postnatal and delivery services, health education, immunization, and dai (traditional births attendant) training

MSH training activities seek to develop a larger cadre of female health workers at three specific but interrelated levels· 1) mid-level, 2) village-level, and 3) household-level. A referral system has begun to take shape in areas of northern, eastern, and central Afghanistan. Personnel now being trained will become important members of a future rural health care delivery system which is now in its earliest phase.

1 Mid-Level Training of Maternal Child Health Officers

Established by the MOPH in late 1990, the Mother and Child Health Officer (MCHO) facility in Peshawar is responsible for training female mid-level personnel in a one-year course. All efforts were made to recruit women from within Afghanistan for the first class, but this proved extremely difficult due to distance, lack of relatives with whom to stay, etc Only four out of the initial class of 11 came from Afghanistan, with the remainder being Afghan women refugees in Peshawar The first class will graduate in March, 1992, and will be posted as soon as possible inside Afghanistan in supervisory positions at the district level. A second class will begin in May, seats have been reserved for women nominated by the AHSA, but it is uncertain how many females from inside Afghanistan the committees will be able to recruit for training in Peshawar.

With the assistance of the MCH Department of the MOPH, the MCHO training center has set up an impressive model clinic for practical training in a nearby refugee community of Tajabad. Students are on rotation there, and they also learn dai training methods and community outreach techniques at the household level Although not presently inside Afghanistan, the MHCO model is one which can be replicated across the border in the future AHSA members plan to establish MCHO training centers in their areas

and note that female recruitment will be easier when decentralized SCNA in the north is ready to establish a training center in Telaqan, and HCCA has similar plans in Beysud

MCHO students in Peshawar are obtaining excellent practical experience in community outreach in the households of Tajabad, and this will serve them well in their future undertakings inside Afghanistan

The MCH Department also provides MCH refresher training to male mid-level health workers and physicians periodically

2 Village-Level Training of Dais

The recent Demographic and Health Household Survey in Wardak province (MSH 1991) showed that 66 percent of the deliveries were accomplished by a local dai This type of active health practitioner is being trained by female staff at 14 dai training centers located at MSH-assisted MCH Clinics throughout Afghanistan A total of 159 dais has been trained in comprehensive 6-week courses which utilize a detailed curriculum from The Afghan Female Health Worker Manual produced by the Chief Commissionerate for Afghan Refugees in 1991. This volume has been recently translated into Farsi with MSH assistance. All trained dais are provided with basic kits which are resupplied periodically.

1500 male BHWs have been instructed at Peshawar-based MCH Department-sponsored workshops in dai training (a 3-step mini-course including hand washing, cord care, and ORS) and they have in turn taught an estimated 4000-6000 dais within Afghanistan Initial assessments of such training activities in Takhar province have yielded positive results, although additional evaluation needs to be done.

In Peshawar, MCHO students are able to obtain excellent practice in training dais during their fieldwork in the nearby refugee community of Tajabad In addition, the dai 3-step mini-course is also part of the CMCEP curriculum.

3 Household-Level Training of Female Community Health Workers (CHWs)

An MCH Outreach Workshop was held in late November, 1991, which was attended by members of the AHSA and MOPH committees, and all groups are in general agreement to foster this group of volunteer village women (CHWs). This will enable secluded women who do not have access to other health personnel to be reached within their households through indigenous social networks

A special working group has been formed concerning CHWs, and a workshop for trainers is planned for April, 1992. Trainers will be existing MSH-sponsored health personnel--both male and female. Training will be at the community level and will embrace many general health tenets included in the Female Health Worker Manual.

MSH staff is in the process of developing basic indicators for the evaluation of CHW performance. To date the MOPH has plans to begin training in Kandahar, Nangarhar, and Ghazni. Both HCCA and SCNA are also ready to begin training in their respective regions. The program will be kept small initially, and a total of 15 women will be trained in each of the four geographic areas.

B. International Medical Corps

The patient load of IMC's 59 health facilities within Afghanistan in the past year was composed of 22 percent adult females and 10 percent girls (14 years and under) Last year, IMC claims to have vaccinated 81 percent of its target population of children under 5 and 68 percent of that of women. IMC is well aware that health priorities have changed from war-wounded to issues such as diarrhoea, etc., in recent years. It does have plans to set up ORT corners in its facilities and expand its EPI activities, but no coordinated MCH program is present or planned.

Only one out of 23 physicians working at IMC facilities within Afghanistan is female; she and two female support staff members (a nurse-midwife and a nutritionist) work in a hospital in Kapisa. Thus there are three females included on an in-country staff of more than 200. Difficulties in recruiting women in the conservative context of Peshawar were noted by IMC expatriate staff as factors limiting female participation.

Community-based outreach MCH activities are not a priority for this clinic-centered organization.

C. Mercy Corps International

MCI is intent upon developing an MCH component of its program due to the high attendance of women and children at its facilities on both sides of the border. It has trained five MCH Assistants (literate health educators) in Quetta; four are from Ghazni and one is from Kandahar. Their course work was completed in September, 1991, and they left for their homes in Afghanistan in December. There they work as clinic staff in previously existing MCI clinics. A new course for MCH Assistants is scheduled to begin in Quetta in April, 1992

Although the recruitment and training process is still unclear, MCI does have a plan to train a variety of female health personnel within Afghanistan in the future. These will include 1) 6 mid-level health workers to support its planned MCH clinics, 2) 10 MCH Assistants, and 3) 320 Community Health Promoters (dais and other women). A total of 10 MCH annexes are planned for the future in conjunction with MCI clinics, along with one MCH center.

(NOTE: MSH and MCI both report that staff in facilities supported by them have reported demand for oral contraceptives and condoms.)

D. International Rescue Committee

Through the PVO Support Project for health activities, IRC funds the 24-bed Afghan Obstetric and Gynecology Hospital in Peshawar. This crowded facility provides in-patient care for more than 500 women/month and out-patient perinatal care for more than 2000 women/month. Patients are refugee women from throughout the NWFP. All of the staff is female, and this includes more than 10 Afghan physicians, some of whom volunteer their services. This facility also serves as a practical training site for the students of the nearby MCHO center. The Afghan medical director and founder of the hospital is planning to move the facility into Afghanistan (Nangrahar province) in the future; he hopes that it can serve as a practical training center for the medical school in Jalalabad.

(NOTE: IRC also organizes and conducts training courses in management, accounting, etc., for Afghan NGOs. A number of these are concerned directly or indirectly with MCH issues.)

In summary, MCH activities in place and planned by O/AID/REP-funded CAs have increased markedly during the past two years. The ability to reach female patients has exceeded most predictions, but efforts to date are but a beginning.

RECOMMENDATIONS

- O/AID/REP grantees should move training activities for females at all levels into Afghanistan as soon as possible to allow for more successful recruitment.

- As trained female staff become available, MCH activities should be initiated in areas where health programs have been active, accepted, and appreciated for some time.

- Implementing agencies should strive to develop referral systems between household-based, village-based, and mid-level female health personnel wherever possible for improved perinatal care.

- Implementing agencies should stress dai training for those women who are active in this traditional labelled profession; where interest exists, consideration should be given to training interested women who are not classed as dais as Community Health Workers.

- Implementing agencies should organize workshops for staff at all levels concerning the support of community-based outreach and communications techniques for both male and female health personnel in order to prepare them to better reach secluded women who otherwise do not benefit from MCH programs.

- O/AID/REP should support operations research as fee-for-service plans are activated in order to ascertain if there are any changes in the proportions of the gender of patients seen as a result of the fee-for-service.

V. Monitoring and Health Management Information Systems

> "Assess progress on the development of the health information and health management systems (e.g. the MSH provincial health surveys). Are the data these systems are designed to obtain appropriate for program monitoring, development, implementation and any necessary redesign".
>
> "Can more systematic use be made of the existing monitoring systems of IMC, MCI and MSH to provide better empirical bases for technical and logistical funding decisions".

The scarcity of reliable and on-going program data is a severe constraint to monitoring and management for all organizations attempting to initiate and maintain health programs within Afghanistan. For O/AID/REP-funded programs, the challenge to redress this situation from Peshawar-based organizations is immense given the size of the country, varying regional accessibility throughout the year due to terrain and weather conditions, and the ban on foreign travel inside Afghanistan necessitating total reliance on either Afghan monitors sent from Peshawar and Quetta or local monitoring from within country. These difficulties have been met in a number of creative ways to

help provide assurances of program activities, obtain additional data to clarify the Afghan health situation and provide credible information to implementing organizations. This information is useful to make rational and critical program management decisions as resources become more scarce among donors.

A. Management Sciences for Health

Of the O/AID/REP-funded health programs, MSH-funded activities have the most developed monitoring and health information systems. All MOPH or AHSA facilities funded by MSH maintain "greenbooks" of patient registers kept on a daily basis to record basic data on each patient and treatment received. At present, all these books are sent to MSH Peshawar. Since the amount of data from literally hundreds of books is immense, MSH can do only sample analysis of these books to monitor patient load at select facilities, disease patterns, age and gender breakdown of patients and other general indicators. Nonetheless, such data have been useful in "canceling" (no longer supporting) some clinics and rationalizing clinic placement.

Aside from this basic information approach, MSH has completed Health Resources Surveys for 22 of the 29 provinces in Afghanistan and Household Health Surveys in two provinces. The Health Resources Surveys first compiled existing data available from WHO and ACBAR on health facilities within Afghanistan. Subsequently, staff went to each district to attempt to validate the existence of all facilities listed by actual numbers, type of service and staff and correlation of equipment with facility staff. In the latter, an example is whether facilities with an operation theater have a surgeon on staff in order to make full use of all available facilities and equipment services. There has been some complications in the timeliness of the data collection and analysis. While data were being collected in early 1991, MSH expatriate advisory staff were evacuated due to the Gulf War. However, data continued to be collected. During the cross-border ban on assistance from mid-July through December, 1991, further data could not be collected. Thus, correlating field data with the WHO and ACBAR information was bogged down for several months. Nonetheless, the data that have been provided indicate numerous facilities simply do not exist, or that facilities need to be relocated to avoid duplication or serve larger population bases within the rural areas of Afghanistan.

The Health Resources Surveys have allowed the MOPH and the AHSA to reexamine facility site selection based on more accurate information. While there is some indication that both entities have been somewhat reluctant to totally accept the data due to some preexisting bias and perhaps community pressure to provide health facilities in some localities, they have no other data

upon which to refute these surveys. In coordination with the MOPH and AHSA, MSH has been able to use this data to relocate some facility sites, cancel some and decide where new facilities should be located. This has also proved useful to better address the development of facility linkages for referral and supervision.

MSH also carried out Household Health Surveys in Wardak and Takhar Provinces to collect basic household data, determine major disease patterns by gender and age and household expenditures for health care. While there are some variations between the findings within each province, there are some striking similarities on major causes of infant mortality related to acute respiratory infections and diarrheal diseases and high incidence of maternal morbidity and mortality. While these surveys documented family willingness and capacity to pay for health care, particularly for medicines, additional work in this area will be valuable to help determine user fees and other revenue generation based on capacity and willingness to pay for care. MSH plans to cross-check greenbook sample analysis data with the household health survey data from Wardak and Takhar Provinces to compare similarity and/or differences from the two sources.

MSH has an extensive field monitoring system to follow movement of drugs and other equipment supplies from Pakistan to Afghanistan and to visit health facilities on a periodic basis inside Afghanistan. The complexities of such tracking require numerous checks and balances which have been put in place by MSH over time. For the MOPH, MSH delivers supplies and salaries to the Ministry office in Peshawar where MOPH takes responsibility for distribution. The MOPH must provide proper receipts for distribution. For AHSA supplies, the monitoring teams stay with supplies from the MSH Peshawar warehouse through the border up to their deposit at one of the seven designated AHSA central supply depots inside Afghanistan. The monitors are the constant link in the system as it passes through various designated parties to final receipt where the shipment is again recounted and receipt documented at the arrival depot. As for site visits to health facilities, teams visit all facilities (both MOPH and AHSA sites) at least twice a year, weather permitting, to confirm that the sites are operational, staff is in place and drugs and equipment are on hand. Where appropriate, AHSA verification of satisfactory clinic functioning is sought. The monitoring teams are switched on a regular basis to reduce the possibility of collusion among the teams and facility staff and local leadership. Each team also has a camera and takes a photo of all workers and the facility to provide visible documentation along with signatures of all workers. The AHSA pays salaries and

obtains receipts which are provided to MSH Peshawar where signatures and photos of all workers are compared by MSH monitoring staff. While no system can be fool proof in such a complicated cross-border operation, the numerous checks and balances in place minimize the possibility for misuse and mismanagement of the MSH program resources.

B. Private Voluntary Organizations

The three PVOs funded by the O/AID/REP, International Rescue Committee, International Medical Corps and Mercy Corps International, have monitoring systems in place, but of a less complex nature than MSH.

IRC provides grants to two Afghan organizations based in Peshawar, the Afghan Psychiatric Center and the Afghan OB/GYN Hospital for Women and one grant to Handicap International (HI) in Quetta. Since all three of the IRC health subgrantees are located in Pakistan, monitoring is a much easier task than for cross border activities. Aside from on-going financial and technical oversight reviews, IRC recently commissioned evaluations of the Afghan Psychiatric Center and the Afghan OB/GYN Hospital programs and one is planned for HI. These major evolutions are being used by IRC regarding future funding decisions.

IMC employs 18 full-time field monitors, three full-time EPI monitors and 25 temporary on-call monitors. These monitors visit IMC facilities inside Afghanistan, and according to IMC staff, can remain for months in-country. The monitors review patient green books and bring them back to IMC headquarters and/or clinic staff bring them into IMC headquarters during regular debriefings. From these green books, IMC analyzes patient load, disease trends and treatment, type of patients served by gender, age and common complaints.

The MCI health information system is used to track health center personnel, medical supplies issued from the warehouse, and operating expenses of each clinic. MCI uses data collected from clinic records and debriefings with clinic staff to review and analyze patient load, patient break-down for women, children and men and district population changes. MCI has a regularly scheduled system of monitoring and supervision for each center. These visits reportedly are made by a physician, laboratory instructor and non-technical monitor. The visits coincide with medical resupply on a four to six month schedule. These visits are carried out by three supervisory centers, each situated to

cover approximately one-third of the total number of health centers. However, in reviewing the MCI Activity Summary Report covering October 1, 1990, to September 30, 1991, the Team noted only 10 of 39 centers were monitored, and of these, only two received more than one visit.

In general, the PVOs do not monitor their activities as extensively as MSH. Partly, this is due to the fact that MSH does not implement any activities, but provides technical assistance and funding to the MOPH and four AHSAs for program development. In this set-up, MSH performs a dual function of technical assistance and program funding. Because of this, it also assumes total financial accountability and liability for all program implementation funds in its Cooperative Agreement. Thus, to insure the quantity and the quality of services it funds, it has instituted a very stringent monitoring system. While the PVOs are equally concerned about the quantity and quality of their services, they maintain daily program management which implies some built-in checks and balances to the overall program. A U.S. Government ban on cross border assistance for security reasons, from mid-July through December, 1991, disrupted much of the regular health monitoring activities.

Most of the monitoring detailed above is quantitative to validate functioning clinics, staff and drug supplies. One exception to this is monitoring of BHW skills by the MOPH when resupplies are given in Peshawar. At that time the MOPH administers a skills test to the BHWs to assess their competency level. In general, most BHWs undergoing such tests do well. Those that need skills upgrading they are directed to refresher training at a cross-border training site. While the AHSAs have responsibility to technically monitor staff, there is no standardized methodology or schedule for doing so.

O/AID/REP's plan to place a PSC in Peshawar to monitor field operations and assist in the coordination of health activities should strengthen the monitoring and coordination activities among organizations.

RECOMMENDATIONS

- O/AID/REP should coordinate systematic review of data from the Health Resources Surveys and other data sources among the MOPH, the AHSA and other O/AID/REP-funded PVO health activities to stimulate better facility/worker replacement, reduce duplication and strengthen the facility network and referral system among the existing facilities in Afghanistan. The PVOs need to be brought into this process. To ensure their participation, this requirement might be reflected in their future Cooperative Agreements.

- Aside from the non-technical monitoring in place by all organizations, technical monitoring of worker competence needs to be strengthened. There should be standardized skill evaluation proforma and review schedules for all levels of workers developed and agreed to by the MOPH, AHSA and the O/AID/REP-funded PVOs.

- Each health Cooperating Agency funding proposal should include an acceptable coordination plan, and an evaluation and monitoring plan.

VI. INSTITUTIONALIZATION

A. Pyramidal Health Systems

> "What has been MSH's role viz-a-viz the NGOs and other donors in developing Afghanistan's health care system and "strengthening the capacity" of the AIG/MOPH and regional health committees to plan and manage an expanded pyramid of health services inside Afghanistan? Should it maintain or alter that stand? How can the PVOs be supportive? What is the potential for coordination with other donors? What actions can be taken now to facilitate the successful merger of the AIG/MOPH, the Regional Health Committees and the Kabul government MOPH?"

The Swedish Committee for Afghanistan and MSH have been the only implementers concerned with development of rural primary health care systems within Afghanistan. This statement embraces the United Nations organizations (with the singular exception of WHO in one important instance discussed later), other "bilateral" donors (including the Norwegian Committee, the EEC and the Germans) and a multitude of PVOs from many countries, including those supported by the O/AID/REP. The statement excludes the system developed through the Kabul government, about which we have insufficient information.

Almost without exception, the health activities of each of the aforementioned entities focused initially on providing curative medical care for war-related conditions, an appropriate response by the international community given the conditions at the time. Most relied heavily upon the training and deployment of a large number of categories of mid-level health workers either developed in accord with the felt needs of the funding agency or hired from a pool trained by others. Most established clinics and hospitals within Afghanistan, usually in response to requests from political parties or local commanders. Many employed Afghan physicians, nurses and other qualified technical personnel (e.g., the Swedish Committee, MSH), and some deployed

teams of their own nationals inside Afghanistan (e.g., Medecins Sans Frontieres). MSH and MCI trained lower-level primary care providers, MSH the Basic Health Worker with three months training, and MCI a first aid worker with two months training.

The SCA assistance program as it has evolved incorporates a number of elements which characterize pyramidal systems. It earlier used the typical manpower pattern of physician/nurses, mid-level and lower-level providers. For the lower-level provider, SCA relied on first aid workers trained by the International Committee of the Red Cross. This category did not demonstrate its worth after the level of war injuries dropped; SCA has eliminated them from its roles and has not developed the equivalent of a community health worker. The closest it currently comes to providing community-based care is the use of some teams of mid-levels and/or physicians who operate from their own homes rather than from clinics. This method is curative in orientation, of limited scope and has no potential for maintainability or replication in a national health system except as these teams become private practitioners. SCA has begun to decentralize its operations with the creation of two field offices (Wardak and Takhar) and plans to establish two more. The field officers recruit potential employees and provide monitoring, logistic resupply and some supervision to more peripheral units. SCA plans to encourage those entities providing refresher training in x-ray, laboratory, dentistry and anesthesiology to provide the training at the field offices, and is considering the possibility of providing its own refresher training of mid-levels there, using the curriculum of the CMCEP. The SCA "respects" the MOPH/AIG, but does not consider it capable of managing SCA's facilities. It distrusts and shuns the AHSAs. As a result, the health system being established by the SCA has no indigenous structured political backing other than as established with local commanders, and is totally managed by SCA.

In earlier years of the war, an Alliance Health Committee (AHC) had been established in Peshawar, initially by health representatives of the most powerful political parties. The AHC later became the MOPH of the AIG. Ever since its arrival in Peshawar, MSH has worked with and through the AHC/MOPH, while all other implementing entities have dealt directly with political parties or commanders across the border. To a very great extent this pattern has continued.

Beginning in 1989, MSH began working with regions within Afghanistan which in addition to military influence had some semblance of civil authority, including provision of schools, development of roads and a limited tax generating capability. Health committees- in MSH parlance Area Health Service Administrations - were formed in these four areas, and have been described in Chapter II. The MOPH and the AHSAs both are

attempting to develop pyramidal health systems infused with PHC concepts, with use of a hierarchal structure of manpower and facilities. The AHSAs have been more successful than the MOPH because of the latter's inability to date to establish and maintain a cross-border presence and identity. The BHWs trained by the MOPH's Institute of Public Health form the community health worker base for both systems. Refresher training for the BHWs increasingly has emphasized PHC, and has been decentralized to 6 sites within Afghanistan. Medical logistics resupply and payment of health workers similarly has been decentralized and increasingly cross-border health workers receive resupply and salaries from the four AHSAs.

A recognized weak link in the systems of the MOPH and the AHSAs has been that of supervision. Efforts by the MOPH to develop and establish Provincial Health Offices and Officers have been disappointing and ineffective to date. The MOPH and the AHSAs are awaiting the graduation and deployment of two new categories of supervisory level personnel to shore up the vital supervisory function. The first classes of these two categories, the Rural Health Officer and the Maternal Child Health Officer, will graduate in April, 1992.

The WHO made a significant contribution to future development of pyramidal health systems by arranging for the formulation of a masterplan in Geneva for a post-settlement health delivery system produced jointly by MOPH representatives of the Kabul and AIG governments. Both MOPHs and WHO signed the document, and it is infused with PHC and a pyramidal health structure developed largely by the AIG representatives.

As far as the Evaluation Team could discover, no other pyramidal health structures are being developed, nor are other donors supporting the two described above except as UNICEF provides vaccines. The PVOs supported by the O/AID/REP and the cross-border projects supported by other donors largely are stand-alone operations. They provide needed (largely) curative services, but are not contributing to institutional development. None of the entities with whom we spoke had experience with attempting to work closely with the MOPH or with the AHSAs, but many had extremely negative things to say about each. The Team could not pin any of these agencies down on the reasons for their negative feelings, but almost universally they view the MOPH (except as a training entity) ineffective and the AHSAs as MSH creations which have no substance, or as opportunistic bodies established "to rip off the donors" or to divert medical supplies and personnel to military areas and away from care of civilians. We clearly have an image problem here. The Evaluation Team met with Peshawar-based medical liaison personnel of the AHSAs and were persuaded that all the groups were dedicated to the development of quality PHC. MSH has provided extensive monitoring of the health services in the AHSAs (see Chapter V)

and has not found great variations from what was expected. While there undoubtedly is room for a great deal of improvement of the MOPH and the AHSAs, we believe that absent any clear reason to the contrary, AID/Rep and MSH should continue support of each.

If O/AID/REP does continue to support the MOPH and the AHSAs, it should require O/AID/REP-supported entities to coordinate with those entities. Recommendations concerning this were presented in Chapter II.

RECOMMENDATIONS

- Unless clear reasons to the contrary arise, O/AID/REP and MSH should continue to vigorously pursue development of pyramidal PHC health care delivery systems through the MOPH and the AHSAs.

- O/AID/REP should liaise closely and sufficiently with other donors to encourage their coordination and cooperation with the MOPH and the AHSAs.

- O/AID/REP should do what it can to influence increased coordination between UN agencies based in Kabul with their Pakistan-based affiliates and support their lead in generation of coordination and cooperation between the Kabul and AIG MOPHs.

B. Strategies For Moving Inside Afghanistan

"Have MSH, IMC, and MCI developed workable strategies for moving their programs inside? What is recommended?"

1. Management Sciences For Health

MSH has formulated a general strategy for movement into Afghanistan, and all staff members are prepared to transfer their activities inside the country. It is anticipated that this could be accomplished within a few months, with only procurement facilities remaining on the Pakistan side of the border.

The performance of MSH over the last six years of its CA positions it well for transition to a Kabul-based program. It presently has seven logistics depots within Afghanistan, along with six cold chain freeze points. Increasingly, salaries for employees inside the country are paid from centers on that side of the border. In addition, BHW refresher training is being accomplished at five training centers within Afghanistan itself

No one knows how the rural-based systems of health care delivery (supported by MSH) will be meshed with the urban-based health system of the present regime as part of the settlement. In post-settlement Afghanistan personnel in the present MOPH/IPH now based in Peshawar could furnish needed expertise in management, training, and materials production techniques. Undertakings such as these may be welcomed both by the new government and by donors.

The four regional committees of the AHSA have all assured MSH that they are willing to join a ministry of health when a central government is formed in order to serve as regional health services under the umbrella of the central ministry in Kabul. This decentralization likely will be a fact no matter the terms of the formal settlement.

2. International Medical Corps

When asked, IMC did not share with the Evaluation Team any specific plans it might have for moving inside Afghanistan. The Director noted that expatriates were unable to travel into the country and thus he found planning for the future of the program very difficult. He also mentioned that IMC historically has been more concerned with regions of the world where emergency situations exist, and its present activities in places such as Mogadishu and Angola might receive a higher institutional priority.

The Team member asked if IMC would perhaps attempt to develop specific programs inside Afghanistan in the area of origin (Nangarhar) of the refugees in the Nasir Bagh Camp (the location of IMC's refugee clinic/practical training site in Peshawar), as IRC was presently doing with groups of refugees with whom it has worked. The Director replied in the negative, noting that Nangarhar already had enough health facilities.

In brief, IMC will apparently continue in its largely curative mode to provide health services inside Afghanistan--with its base in Peshawar - and continue the CMCEP refresher course for mid-level health personnel. Plans for moving any training or administrative activities inside Afghanistan by IMC were not shared.

3. Mercy Corps International

In contrast to IMC, MCI has set forth some specific plans for its move inside Afghanistan Facilities for both teaching and treatment are being constructed at Bagh-i-Pul, which is approximately 8 kilometers distant from the city of Kandahar in southern Afghanistan. At present construction is 80% complete

There are also plans to construct a warehouse and dormitory facilities at this site. MCI will organize a carefully phased transition of personnel and activities and is anticipating that this will be accomplished by Spring 1993. The cost of the move has been estimated to be $20,000.

MCI characterizes its activities as an evolution from curative to preventive care which will form the core of its anticipated peace-time services. In this regard, it is planning the establishment of 10 MCH annexes in conjunction with already functioning clinics, along with the establishment of a larger MCH center. All Afghan staff being hired presently in Pakistan are on pledge to make the move into Afghanistan when feasible.

RECOMMENDATIONS

- O/AID/REP should continue to fund its current CA portfolio over this transition period to facilitate program relocation inside Afghanistan.

- O/AID/REP should officially confirm intent of each CA to move programs inside Afghanistan and request transition plans in order to set program priorities and funding levels.

C. The International Rescue Committee Cooperative Agreement

"What is the likelihood that the health activities being supported through the IRC Cooperative Agreement will make the shift inside Afghanistan? How should these activities fit into the total overall A.I.D. health strategy?"

Important health activities supported through the IRC Cooperative agreement at present are: 1) the Afghan Obstetric and Gynecology Hospital in Peshawar and 2) Handicap International which is based in Quetta.

1. The Afghan Obstetric and Gynecology Hospital

The Afghan physician who directs this active hospital originates from Nangarhar in eastern Afghanistan, and he has plans to move his staff and equipment inside to a site near Jalalabad. Previously having had links with the medical school in this city, he hopes to be able to affiliate with the medical school and utilize the re-established ob/gyn hospital as a practical training site for female physicians and other female health workers. The Peshawar hospital is presently a site where mid-level Maternal Child Health Officer trainees obtain practical experience.

IRC has arranged for an evaluation of this institution which should be completed soon. The Afghan OB/GYN Hospital could be a valuable component in a pyramidal health care referral system in the area of perinatal care, along with serving as a future site for MCHO practical training.

MCH is a crucial area of primary health care in the Afghan context. It is an area upon which O/AID/REP funding limitations have not been placed; similarly, staffing limitations pertaining to female personnel have not been established. In short, MCH issues are of top priority and, in this respect, a relocated Afghan OB/GYN Hospital has potential importance as a clinical facility and training institution for MCH which will be decentralized from the capital city of Kabul.

2. Handicap International

Handicap International, with its home office in Belgium and its field office for Afghans in Quetta, is presently setting up prosthetic rehabilitation units inside Afghanistan in coordination with clinics of MCI and the Islamic Aid Health Center, an Afghan NGO; these are located in Ghazni, Kandahar, and Helmand provinces. Demands for prostheses in these clinic locations have been low, however. Handicap International is thus in the process of coordinating with WHO, UNDP, ICRC, and other multilateral organizations concerning prosthetic demands of various regions of the country, standardization of technology, etc. An evaluation of HI by IRC is scheduled to begin soon.

One Evaluation Team member who was recently in Kabul is aware that the need for prostheses is great, and that WHO is seeking assistance in this effort. A possible snag is that Handicap International's prostheses are relatively low-tech. Patients may desire the more esthetic higher-priced prostheses available elsewhere. The technology used by Handicap International certainly is appropriate technology, however, and WHO likely will welcome its participation, along with other NGOs such as the Sandy Gall Afghanistan Appeal based in Peshawar.

* * *

Concerning IRC itself, the Director of the organization in Peshawar has noted that even though this has been a refugee assistance group, the organization anticipated that it would move its headquarters to Kabul if a suitable political atmosphere is achieved. IRC would coordinate with the Afghan government for an interim period of a few years.

IRC is presently implementing cross-border programs in Afghanistan through its Rehabilitation Program for Afghanistan largely in the area of agriculture, and anticipates that these undertakings will continue and be coordinated from Kabul post-settlement.These activities inside Afghanistan represent the first time that it has also worked in the IRC-assisted refugee population's country-of-origin. If indeed the agricultural activities continue post-settlement, the likelihood of similar IRC interest in health activities is high.

In order to better coordinate the NGOs under the Cooperative Agreement and others, IRC has hired a Project Officer. Audits and evaluations have been undertaken, and technical assistance in management is being provided. IRC is soliciting proposals for additional future undertakings in Afghanistan especially from Afghan NGOs, and it is primarily interested in working with programs in preventive health: water and sanitation, EPI, dai training and community-based health education.

Given the possibility of IRC's move inside and its highly professional approach to selection, funding, and technical assistance of NGO activities, IRC can play a more pivotal role in the development of indigenous groups and decentralized services. This approach complements other O/AID/REP health activities and effectively creates an umbrella mechanism to widen support for priority PHC activities.

RECOMMENDATIONS

- O/AID/REP should continue to provide funding to the Afghan OB/GYN Hospital when it moves inside Afghanistan and structure support to also use it as an MCHO training facility.

- Because rehabilitative prosthetic activities are not a high A.I.D. priority, O/AID/REP should not provide future funding to Handicap International unless special or ear-marked funds are available. There is no question that there is need for such activities.

- O/AID/REP should allow IRC a more proactive role in soliciting proposals from qualified Afghan NGOs working inside Afghanistan and structure its CA to provide technical assistance and management expertise as necessary to subgrantees.

VII. Financial Affordability

A. Training

"Evaluate the training facilities of each entity and advise how these may be down-sized or restructured to reduce costs while at the same time produce high quality graduates."

At present the MOPH, the AHSA, IMC and MCI have training facilities funded through their Cooperative Agreements with the O/AID/REP. All the CAs have initiated different types of training at somewhat different times over the last five to six years according to their and O/AID/REP-perceived program needs. Because of the diverse nature of these training programs, they are not easily comparable nor is it possible to get cost data due to the different types of financial records kept and computation formulas each CA uses to determine training costs. Some observations, however, may be offered on the current training situation with recommendations based on the admittedly limited data available.

With so many groups operating separate training institutes both in Pakistan and now Afghanistan, training expenses in the overall O/AID/REP program have risen. Yet, immediate future training needs are diminishing with the O/AID/REP current mandate to limit the number of new workers and facilities (with exceptions for female health workers and MCH clinics) to better control recurrent costs and underscore a commitment to improving quality vis-a-vis increasing quantity. These changes necessitate a review of training needs and how best to accommodate those needs while realizing cost efficiencies and savings.

Of the groups reviewed during this evaluation, IRC does not conduct health worker training. MSH supports training through the MOPH/IPH in Peshawar and six AHSA regional training institutions inside Afghanistan. The MOPH/IPH conducts its clinical student practicum training in refugee camps or available clinic sites in the Peshawar area. The ASHA regional training institutes make ready use of existing clinics that are part of the rural PHC program for student practicums. This makes optimal use of existing facilities and represents a field situation in Afghanistan from which new workers are likely to learn most. IMC operates two training institutes, one in Nasir Bagh with a

teaching hospital and one in Thal. The Thal training institute is scheduled to close by June 30, 1992, after one more CMCEP class graduates. MCI operates one training institute in Quetta also with clinical teaching facilities through Al-Jehad Hospital and its MCH clinic. The cost to maintain IMC and MCI teaching hospitals in Pakistan is expensive compared to using Afghanistan facilities and does not serve the long term institutional needs of Afghanistan nor provide care to people inside Afghanistan. Given the emergence of other training institutions inside Afghanistan that are more field-oriented and cost effective, prolonged O/AID/REP support for these facilities within Pakistan is questionable.

Although it is difficult to confidently assess the quality of these varying institutions and the many training courses and graduates from these institutions over the last few years, the Team felt overall the training efforts have been very impressive under the circumstances. Attempts at standardizing curriculum and certification of workers is an excellent move to further enhance training quality and turn out well qualified graduates (see Chapter III, Training).

RECOMMENDATIONS

- O/AID/REP should analyze training needs given its worker/facility cap in order to determine the appropriate number of training institutes, locations and types of courses.

- O/AID/REP should support transfer of currently funded training facilities from Pakistan to inside Afghanistan as soon as security conditions permit and no later than 120 days after establishment of the U.S. Embassy in Kabul.

- O/AID/REP should require comparable training cost data from IMC and MCI to determine training costs under its existing arrangements and possible cost savings alternatives (i.e. use of other clinical settings or limited support for select operations such as the MCI MCH clinic) in order for them to be considered and qualify for future funding for training activities.

B. Cost Cutting and Revenue Generation

"Examine the plans and programs of IMC, MCI and MSH at cost cutting - particularly in the areas of reducing pharmaceuticals and medical equipment supplied inside - and their implementation of revenue generation (fee-for-service and charging for medicines) efforts. Make recommendations for improvement".

High program recurrent costs can no longer be sustained by the O/AID/REP for health sector activities. The two largest budget support items, drug costs and worker salaries, must be reduced beginning this year to build in long term program affordability and develop a framework for cost-sharing mechanisms for the post-settlement program. Recent MSH household surveys carried out in Wardak and Takhar provinces in Afghanistan indicated that many patients are paying for health care services and drugs. While the issue needs to be explored in more depth to realistically determine fee structures and other possible revenue schemes, it is encouraging to validate that there is some capacity and willingness of patients to pay for services.

As part of overall efforts toward program cost containment and financial affordability, the O/AID/REP recently instituted two major policies designed to control drug costs and worker salaries of all Cooperating Agencies:

1. Combined Drug and Equipment Procurement

All CAs must participate in the A.I.D. combined procurement system in which MSH consolidates orders with IMC and MCI for procurement by RONCO (a US-based firm which has a contract to procure all O/AID/REP procurement). This recent move was designed to reduce overall costs through bulk pricing and also standardize the price, quality and number of drugs provided to IMC and MCI. For the most part, these drugs are procured from the Pakistan market by RONCO and shipped directly to each group, i.e. MSH, IMC and MCI. Although IMC and MCI have participated in only combined drug procurement, their future equipment needs will also be incorporated with MSH procurement. MSH pays for all drugs and equipment procured through its budget which includes separate line items for IMC and MCI procurement.

2. Salary Reductions and Cost-Sharing

All CAs must cut health worker salaries. MSH must cut clinical staff salaries by 25% beginning April 1, 1992. A further 25% cut will be made beginning October 1, 1992 for clinical staff (total 50% cut overall) and 25% for other categories of staff. Other CAs must institute the first 25% cut

by July 1, 1992, and the second 25% cut by October 1, 1992. Simultaneously, fee-for-services charges or other health revenue-generating and cost-sharing activities at health facilities should be introduced.

Through its procurement system, MSH provides drugs, medical supplies, cold chain equipment, MCH supplies and all equipment for supporting its implementing agencies' health services programs inside Afghanistan. In FY 91, $3.6 million of pharmaceuticals, medical supplies and equipment were ordered. Of that, about $2 million was for drugs. All pharmaceuticals, medical supplies and equipment account for 40% of the total program budget, while drugs generally account for approximately 30% of the total program budget. Over time MSH has carried out a systematic review of its drug supply list resulting in decisions to cut back drug amounts for some items by approximately fifty percent and to eliminate three drugs, including the purchase of expensive multivitamins (frequently used only as placebos), to realize significant cost savings in its budget. Savings from elimination of multivitamins alone was almost $190,000 for a five month period from August, 1991, to January, 1992. Based on the positive experience of the drug review and corresponding savings achieved through cutting high priced non-essential drugs in the program, a systematic reevaluation of program equipment needs and priorities might prove similarly useful.

Regarding fee-for-service, MSH is instituting the mandated salary cuts of 25% on April 1, 1992, and then subsequently another 25% on October 1, 1992. However, in discussions with both MOPH and AHSA health committee representatives, they indicated it is unlikely that fees will be instituted by April 1, 1992 as these organizations expressed reservations about doing so until a unified plan is worked out and public awareness campaigns are carried out to avoid a perceived client backlash to fees. More than likely salaries will be cut without fees in place, and initially patient loads may drop, some less-utilized facilities will be "canceled" and possibly drugs may be sold in the market by health workers to recoup their loss in salary.

IMC claims the combined procurement system is not working because it is unable to get all drugs through the MSH standard list nor does it save money. Rather than join in the attempt to minimize the number and variety of drugs at its facilities, it has gone to the local market and made drug purchases in spite of O/AID/REP instructions to the contrary. IMC does not seem to have made efforts to reduce its pharmaceutical cost, nor is there any indication it plans cuts in equipment costs. IMC is totally against fee-for-service charges at this time, and unlikely to willingly implement fees this year.

MCI is participating in the combined drug procurement and seems fairly satisfied. It, too, expresses a need for some drugs not provided through the MSH standard list and has bought some low priced items from the market for its program; however, it is not resistant to the combined procurement system. As a result of combined procurement, MCI has cut its drug list and corresponding expenditures on drugs. MCI has the most experience in fee-for-service charges. It has instituted clinic entrance and hospital fees and patient charges for drugs and x-ray film at its Quetta facilities. Although the cost recovery is admittedly small, MCI is comfortable with the concept and is planning to institute fees in its cross-border facilities. It has already started fee-for-service at one clinic inside, but has not yet evaluated it. MCI also expressed an interest in coordinating with MSH and accessing the services of the health financing advisor. Overall, MCI has demonstrated the most tangible and positive response of any CA to cost containment and revenue generation.

Because of the caps on new facilities, bulk procurement will reduce costs, at least for drugs. Equipment costs, while a high capital outlay over the last several years for all implementing organizations, are likely to be reduced and stabilized for the next few years until replacement items are required. While the CAs are struggling somewhat with the mandated salary cuts, this is an appropriate step to begin the process of cost-sharing with both the clients and local administrative bodies within Afghanistan. No donor can support such high recurrent costs indefinitely.

RECOMMENDATIONS

- O/AID/REP should require all CAs to participate in the combined drug and equipment procurement as a condition of funding.

- MSH should do a systematic review of its equipment and supplies list by no later than August 30, 1992 (similar to the drug review done in July 1991) to identify areas for reduction and cost savings.

- All future CA proposals and annual workplans should include cost containment plans.

- O/AID/REP should assure that the health financing advisor recently hired through MSH is fully utilized by O/AID/REP-supported implementing agencies, particularly the PVOs, to develop fee schedules and other possible strategies for revenue generation, including patient drug purchase.

- After implementation of revenue-generating and cost-sharing activities, O/AID/REP should commission research on client willingness and ability to pay for services on a regular basis and other contributing factors in order to better structure revenue generation/cost saving schemes.

C. Salary Levels and Standardization

"Assess salary levels paid (among O/AID/REP funded programs) to health workers inside and needs and efforts to standardize these salaries and other benefits provided"

There exists a wide range of worker salaries among the O/AID/REP funded CAs and even more so when other organizations are reviewed. As far as we could discern, each organization has created its own structure which has worked well for it for many years; they therefore show little interest in creating comparable salary levels. In the past, this has created problems with workers shifting around among organizations to obtain the highest paid position possible. For the short term, these disparities create problems both to cover recurrent costs and also for competition of workers among several employers. A more important and long term issue that will emerge upon transfer of the program to Afghanistan is the reconciliation of relatively high donor-supported salaries (said to be ten to thirty times higher than Kabul Government salaries) with local salaries and economic conditions in Afghanistan. Although the O/AID/REP plans to withdraw from salary support over time, it should attempt to determine what are reasonable salaries should it review the present program strategy and continue some salary support.

Of the O/AID/REP funded CAs, the bulk of salaries are through MSH-supported programs inside Afghanistan. MSH has standardized salary levels by worker category that is administered across the board. Of salaries compared between MSH, IMC and MCI, a range exists among each worker category noted in Table 1. The Team did not have salary scales for IRC projects, so could not include them in the comparison. In general, the lowest salaries are paid by MSH. MCI, with the exception of salaries for lab and x-ray technicians, pays the highest salaries. IMC salaries generally fall in the middle of the three CAs for which salaries were compared. Although the Team was not requested to compare other organizations' salaries, we also compared SCA and MSH salaries since SCA presently supports (and plans to continue) large numbers of workers and facilities inside Afghanistan, similar to MSH. SCA salaries are about one-third lower than MSH salaries across the board (we could not do full comparison as all details on SCA fringe benefits were not readily available), with the exception of lab technicians which is about sixty percent lower than MSH. When MSH set salaries it reviewed

prevailing wages paid by the various groups that were supporting Peshawar-based and cross-border health activities at the time and created a middle range between the lowest and highest salaries offered. Because of the large numbers of workers supported through MSH, overall salary support is the largest budget item of all program components.

RECOMMENDATIONS

- O/AID/REP should mandate as a condition of continued support a standardized salary scale range by worker category among all CAs to create some program service/cost uniformity. (The MSH scale may be deemed appropriate or O/AID/REP might wish to review other major organizations salary scales, including SCA, for comparability).

- O/AID/REP should obtain levels of professional salaries for all categories of health workers in the Kabul Government from WHO or the wage survey currently in progress by ACBAR in order to plan for realistic salary levels should O/AID/REP continue some salary subsidy post-settlement.

TABLE 1

SALARY SCALE
(in Rs.)

TYPE OF WORKER	MCI	IMC	MSH	SCA
MD-Specialist	-	-	6,527 to 7,577	-
MD-Generalist	7256	6,600	5,457 to 6,157	4,500
Nurse	3,556	-	2,996 to 3,521	2,000
Mid-Level	2,665	3,000	1,284 to 1,926	1,000 to 1,500
Technicians x-ray & lab	2,665	2,100	2,996 to 3,371	1,000
Vaccinators	-	2,100	1,284 to 1,534	?

Notes:

1. Salaries include base and fringe benefits, except for SCA which notes that other fringe benefits range from Rs. 1,500 to 7,000 per month/per facility depending on number of people and level/quality of facility.

2. Data obtained from O/AID/REP salary scale table dated November 1990.

VIII. PROGRAM MANAGEMENT

A. Project Management

"The team will review the financial, contractual, and programmatic issues involved in the merger of AID/Rep's MSH and PVO activities under an umbrella health project. The team will recommend if such a merger should be made, and if so, how it should be accomplished - to include the structuring and timing of a possible merger".

The HSSP and the PVO Support Project are managed by the O/AID/REP Health Office. Earlier they were managed by the Health and Education Office, with the portfolio split up among three officers. Consolidation of these two health projects under a single management unit has been a favorable management move. The question posed in the Scope of Work deals with consolidation of all activities of both projects under a single umbrella project. Because of some similar activities in both projects (training, health services delivery), plausible arguments could be made for such a merger under more typical developmental conditions, including reduction of total management units and the expected benefits of reduced documentation demands associated therewith. The program could be redesigned to implement all current activities under one project through a contract or a Cooperative Agreement with one corporate entity, or with multiple entities. Under the latter arrangement, there likely would be little financial, managerial, contractual or programmatic gain.

The arguments against such a merger in the near future are more external than internal (within USAID), and deal less with management than they do with perceptions and practicalities.

1. The timing of a political settlement is much in doubt. While there is current optimism that it is in sight, there are innumerable ways that it could be derailed. Over the past 6 years O/AID/REP has developed a program which may not be ideal, but is close to the best it can be given the unsettled conditions in the area. It does not seem prudent to jeopardize the gains made by developing a new mechanism to do business at this time. The possible losses appear to outweigh the potential gains.

2. Afghanistan has had little tradition or experience dealing with private voluntary agencies. There is still some question as to how willing and able the reconstituted post-settlement government will be to incorporate or accommodate PVOs within the health structure. The current stand-alone arrangement provides a discrete opportunity for Afghan health officials to become more familiar with the

benefits available from PVOs, and to become comfortable in dealing with them. At the same time, under the current arrangement an attack or political backlash, for whatever reason, against a part of the health portfolio is less likely to damage the entire effort.

3. The O/AID/REP is requiring within the next few months each Cooperating Agency to institute cost-sharing measures which could cause long-lasting disruptions in the program. There is no way to tell at this point how effective or how successful the various CAs will be in implementing these far-reaching and, for Afghanistan, radical changes in the health delivery system. Only after enough time has been given to assessment of the results of these initiatives should consideration be given to a merger or other rearrangements within the portfolio.

4. Most of the current CAs are in advanced planning for a cross-border move with all or part of their activities, yet have the flexibility to continue operating from their current locations. This flexibility should be maintained. It could be impaired if new operating mechanisms were imposed prematurely.

B. Staffing Levels and Afghanization

"Assess the staffing, expertise and placement of the O/AID/REP Health Office Staff, and the expat staff of IMC, MCI and MSH in light of proposed future program directions. Look at the progress and problems associated with Afghanization of management staff".

The expatriate staff of IMC has been reduced to the point that further reductions may limit its ability to carry out the terms of the CA and still remain responsive to the needs of its home office. Leadership would be stronger if the Director had health expertise and experience. Under the terms of the current CA, MCI is to reduce its current staff of 5 expats to 4 by June 30, but has not yet signaled how it plans to restructure. The Director and Administrative Assistant each are half time, as are the Financial Controller and Accountant. These administrative positions likely will continue to be filled by expatriates because of MCI's involvement with health and agricultural projects. There are two nursing positions and one Health Management Supervisor, all three of which are technical positions. It is likely that it is in one of these three positions that a qualified Afghan may be found to replace an expatriate.

MSH remains the implementing agency with the largest expatriate staff (nine): Team Leader, Finance Officer, Logistics Officer, Management Advisor, Training Advisor, Operations Officer, MCH Advisor, Medical Advisor and Health Financing Consultant, the latter on a one-year assignment. In many regards, MSH is serving as an advisory surrogate for O/AID/REP with the AIG, supporting nearly all facets of ministerial activities, including planning, systems management, manpower development and training, PHC technical assistance, logistics, and health and medical services delivery. It is providing many of these same advisory functions to the AHSAs. Additionally, it coordinates standardization and procurement of medical supplies and equipment for the PVOs and directly manages a medical logistics system, an intensive monitoring system and a management information system. For six of the expatriate positions, Afghan deputies are being developed (exceptions are the Team Leader, Finance Officer and Medical Logistics Officer). MSH argues that to satisfy the terms of the CA, including the chosen approach to advise Afghan agencies rather than provide direct services, it has an appropriate sized expatriate staff. The Team agrees that these are all appropriate slots given the MSH scope of work and hesitates to recommend reductions. If, however, decreases in funding levels or the political situation force consideration of reductions in expatriate levels, MSH might consider having the Afghan Deputy for Training take increasing responsibility and provide needed external technical assistance on a consulting basis. Similarly, the management advisory function perhaps could be provided on a consulting basis, but only if management of the three recently acquired Peshawar curative facilities were removed from MSH responsibilities.

"Afghanization", which we interpret to mean the assumption of functions performed by expatriates by Afghans, has been undertaken by all CAs, but there are limits to how much further this can be carried in the near term for several reasons. First is the relative lack of and competition for Afghans with training and experience in technical and managerial roles. Many such individuals with training and experience have emigrated beyond Pakistan, and those few available have been already identified and hired by the many organizations supporting the Afghan program. Other than on-the-job training, in-country opportunities for technical and managerial training are few, and the participant training program is very small. Each implementing agency has the usual internal requirements for planning, financial accountability, monitoring and reporting for which it requires expatriate input. Finally, the competing tribal, ethnic, party and linguistic loyalties increase the difficulties in hiring or training Afghans, no matter how qualified, who can work in the cross-cutting projects sponsored by the implementing agencies as acceptedly and effectively as can a neutral expatriate.

The O/AID/REP Health Office is staffed by a direct-hire Health Development Officer for technical advice, management and coordination, and two personal service contractors, one for administration and one for monitoring of field operations. Until the health portfolio transfers to Kabul, this staff should be sufficient, particularly if the existing "tested" implementing agencies continue to be supported. Once the move is made, staffing levels will need to be reassessed depending on circumstances and funding levels.

RECOMMENDATIONS

- The O/AID/REP should not consider merging the health portfolio into a single umbrella project until post-settlement timing, structure and funding levels become more clear.

- As part of the Key Personnel clause in its CAs, O/AID/REP should require health expertise, preferably at the MPH level and previous overseas health project experience by the Directors of health services PVOs.

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AID FOR ASIA/PCAP/AF AND ASIA/DP/TR/HPN FOR V. SEWELL

STATE FOR NEA/PAB, PP, SP AND IO

E.O. 12356: N/A
TAGS: NONE
SUBJECT: AFGHANISTAN - HEALTH PROTFOLIO EVALUATION

REF: (A) TELECON AND FAX: D. PALMER/W. SEWELL, DATED
- 11/18/91, (B) ISLAMABAD 16891,
- (C) ISLAMABAD 15007

1. AS PROMISED IN REFTELS, THIS CABLE PROVIDES THE SOW FOR THE SUBJECT EVALUATION WHICH IS PLANNED FOR A THREE-WEEK PERIOD TO BEGIN FEBRUARY, 1992.

2. THE EVALUATION SCOPE OF WORK:
A. ACTIVITIES TO BE EVALUATED - BACKGROUND:
THE EVALUATION WILL COVER THE ENTIRE O/AID/REP HEALTH PORTFOLIO WHICH CONSISTS OF THE HEALTH SECTOR SUPPORT PROJECT (HSSP) (306-0203) ADMINISTERED BY MANAGEMENT SCIENCES FOR HEALTH (MSH), AND THREE ACTIVITIES FUNDED THROUGH THE PVO SUPPORT PROJECT (306-0211) AND ADMINISTERED BY THE AMERICAN NGOS: INTERNATIONAL MEDICAL CORPS (IMC); MERCY CORPS INTERNATIONAL (MCI); AND, THE INTERNATIONAL RESCUE COMMITTEE (IRC). PRESENTLY, SIX AFGHAN OR FOREIGN NGOS ARE FUNDED THROUGH THE IRC ACTIVITY.
THE PRIMARY OBJECTIVE OF THE O/AID/REP FUNDED HEALTH PORTFOLIO IS TO DEVELOP AND INSTITUTIONALIZE THE CAPABILITIES OF AFGHAN AUTHORITIES TO OPERATE EFFECTIVE HEALTH DELIVERY SYSTEMS, AND PROVIDE BASIC HEALTH CARE TO THE POPULATION IN RESISTANCE-HELD AREAS, WHICH REPRESENTS OVER 80% OF THE POPULATION LIVING INSIDE AFGHANISTAN - THE BULK OF THE RURAL POPULATION OF THE COUNTRY. A SIGNIFICANT AMOUNT OF ASSISTANCE ALSO SERVES THE AFGHAN REFUGEE POPULATION VIA TEACHING HOSPITALS AND CLINICS OPERATED BY THE GRANTEES IN BORDER AREAS OF PAKISTAN

AT PRESENT, THE O/AID/REP IS THE LARGEST DONOR TO HEALTH DELIVERY IN RURAL AFGHANISTAN AND OUR PROGRAM SUPPORTS OVER 1,300 ONE-MAN BASIC HEALTH UNITS, OVER 300 FULLY-STAFFED CLINICS AND MCH CENTERS, AND SIX SMALL HOSPITALS (TEN TO TWENTY BEDS). WE SUPPLY

SALARIES, EQUIPMENT AND PHARMACEUTICALS TO OVER 2,500 HEALTH WORKERS INSIDE AFGHANISTAN AND OVER 300 SERVING ON THE PAKISTAN SIDE OF THE BORDER. THE HSSP AND THE PREDECESSOR PROJECT TO THE PVO SUPPORT PROJECT WERE BOTH EVALUATED APPROXIMATELY TWO YEARS AGO - IN FEBRUARY, 1990 AND NOVEMBER, 1989 RESPECTIVELY. THESE EVALUATIONS, WITH O/AID/RFP TECHNICAL OFFICER INPUTS, ALTERED OUR HEALTH PROGRAM ACTIVITIES AND DIRECTIONS. THE MAJOR CHANGES MADE INCLUDE:

- (1) PLACING MORE EMPHASIS ON PREVENTIVE HEALTH MEASURES, ALTHOUGH THE MAJORITY OF SERVICES REMAIN CURATIVE.

- (2) CAPPING THE NUMBER OF HEALTH WORKERS AND FACILITIES (AT 10/1/91 LEVELS) WITH THE EXCEPTION OF FEMALE HEALTH WORKERS AND MCH EFFORTS.

- (3) DECREASING SUPPORT FOR RECURRENT COSTS ASSOCIATED WITH THE HEALTH DELIVERY SYSTEM, WITH A FOCUS ON REDUCING THE AMOUNTS AND TYPES OF PHARMACEUTICALS AND SUPPLIES, COMBINING PROCUREMENT, AND INSTITUTING REVENUE - GENERATING ACTIVITIES.
- (4) IMPLEMENTING EFFORTS TO STANDARDIZE SKILL LEVELS AND TRAINING OF HEALTH WORKERS.

- (5) FOCUSING ON A MORE EQUITABLE DISTRIBUTION OF HEALTH SERVICES, BASED ON POPULATION LEVELS AND NEEDS NOW AND AFTER THE RETURN OF THE REFUGEES.

- (6) REORGANIZING THE ORGANIZATIONS, WHICH WE SUPPORT AT THE MANAGEMENT AND DESISION MAKING LEVELS.

B. PURPOSE OF THE EVALUATION:
THE UPCOMING ASSESSMENT WILL PROVIDE A DETAILED STATUS OF PROGRESS MADE SINCE THE LAST ASSESSMENT TOWARDS: (1) THE ACTION DECISIONS GIVEN IN THE PROJECT EVALUATION SUMMARY (PES) OF THE HSSP (DATED 4/90); (2)
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THE OBJECTIVES SET OUT IN THE EXISTING COOPERATIVE AGREEMENTS WITH MSH, IMC, IRC AND MCI, AND (3) THE CURRENT IMPLEMENTATION PLANS AND PROPOSALS OF THE MAJOR GRANTEES. (THE REVIEW TEAM MEMBERS WILL BE PROVIDED COPIES OF THE PREVIOUS EVALUATIONS, THE PES, AND CURRENT GRANTEE IMPLEMENTATION PLANS PRIOR TO THEIR DEPARTURE FOR PAKISTAN.) THE EVALUATION RESULTS WILL ASSIST THE O/AID/REP IN (1) TARGETING ITS FY 92 HEALTH FUND OBLIGATIONS, (2) PREPARING A POST-12/92 HEALTH STRATEGY (WHICH IS THE PACD OF THE HSSP), AND (3) DEVELOPING A PLAN FOR MOVING THE PROGRAM INSIDE AFGHANISTAN AND (4) OUTLINING NEEDS TO BE ADDRESSED BY A FOLLOW-ON PROJECT, EXPECTED TO BE APPROVED IN FY 1993.

C. STATEMENT OF WORK:

- 1. PROGRAM MANAGEMENT:

(A) THE TEAM WILL REVIEW THE FINANCIAL, CONTRACTUAL, AND PROGRAMMATIC ISSUES INVOLVED IN THE MERGER OF AID/REP'S MSH AND PVO ACTIVITIES UNDER AN UMBRELLA HEALTH PROJECT. THE TEAM WILL RECOMMEND IF SUCH A MERGER SHOULD BE MADE, AND IF SO HOW IT SHOULD BE ACCOMPLISHED - TO INCLUDE THE STRUCTURING AND TIMING OF A POSSIBLE MERGER.

(B) ASSESS THE STAFFING, EXPERTISE AND PLACEMENT OF THE O/AID/REP HEALTH OFFICE STAFF, AND THE EXPAT STAFF OF IMC, MCI AND MSH IN LIGHT OF PROPOSED FUTURE PROGRAM DIRECTIONS. LOOK AT THE PROGRESS AND PROBLEMS WITH THE AFGHANIZATION OF MANAGEMENT STAFF.

- 2. HEALTH SERVICES DELIVERY:

(A) ASSESS THE RELATIVE STRENGTHS AND WEAKNESSES OF: THE REGIONAL HEALTH DELIVERY SYSTEMS IN SHURA-E-NAZAR, SOUTH AND SOUTHWEST, PAKTIYA/PAKTYKA AND THE HAZARAJAT; THE AIG HEALTH DELIVERY SYSTEMS IN VARIOUS AREAS OF AFGHANISTAN; AND THE NGO (MCI AND IMC) HEALTH DELIVERY SYSTEMS THROUGHOUT AFGHANISTAN, AND DETERMINE WHETHER THE DESIGN AND IMPLEMENTATION OF THESE EFFORTS IS SUITABLE TO SUSTAINABLE DELIVERY OF HEALTH SERVICES TO THE RURAL AFGHAN POPULATION. ASCERTAIN THE POSSIBILITY AND METHOD(S) OF INTEGRATING THESE THREE SYSTEMS (REGIONAL, AIG/MOPH, AND NGO) UNDER CURRENT CONDITIONS, AND WITH A POSSIBLE FUTURE CENTRAL MINISTRY OF PUBLIC HEALTH BASED IN KABUL.

(B) ASSESS WHETHER THE VARIOUS HEALTH DELIVERY SYSTEMS HAVE MADE SATISFACTORY PROGRESS IN INCREASING THE NUMBERS OF WOMEN AND CHILDREN SERVED, AND MAKE RECOMMENDATIONS FOR FURTHER IMPROVEMENT.

- 3. TRAINING:

(A) JUDGE THE QUALITY AND COSTS OF THE COMBINED MID-LEVEL CONTINUING EDUCATION PROGRAM AT AL JEHAD (QUETTA) AND TRAL AND ADVISE ON ITS CONTINUATION, LOCATIONS AND STRUCTURE. DETERMINE WHETHER THE CONTENT OF TRAINING PROGRAMS IS RELEVANT TO PRIORITY NEEDS INSIDE AFGHANISTAN.

(B) ASSESS THE LABORATORY TECH TRAINING OF THE AID/RFP FUNDED AND OTHER ENTITIES AND ADVISE ON STANDARDIZATION AND INTEGRATION OF EFFORTS.

(C) AS POSSIBLE, LOOK AT OTHER TRAINING EFFORTS WHICH MAY BE COMBINED.
(D) MAKE RECOMMENDATIONS FOR INCREASING THE NUMBERS OF FEMALE TRAINEES AT THE BASIC AND MID-LEVEL HEALTH WORKER LEVELS.

(E) WHAT HAVE BEEN THE QUALITATIVE IMPLICATIONS OF CONDUCTING BASIC HEALTH WORKER TRAINING INSIDE AFGHANISTAN.

- 4. MONITORING AND THE MANAGEMENT AND HEALTH INFORMATION SYSTEMS (MIS/HIS):
(A) ASSESS PROGRESS ON THE DEVELOPMENT OF THE HEALTH INFORMATION AND HEALTH MANAGEMENT SYSTEMS. (E.G. THE MSH PROVINCIAL HEALTH SURVEYS.) ARE THE DATA THESE SYSTEMS ARE DESIGNED TO OBTAIN APPROPRIATE FOR PROGRAM MONITORING, DEVELOPMENT, IMPLEMENTATION, AND ANY NECESSARY REDESIGN?
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(B) CAN MORE SYSTEMATIC USE BE MADE OF THE EXISTING MONITORING SYSTEMS OF IMC, MCI, AND MSH TO PROVIDE BETTER EMPIRICAL BASES FOR TECHNICAL AND LOGISTICAL FUNDING DECISIONS?

- 5. INSTITUTIONALIZATION

(A) WHAT HAS BEEN MSH'S ROLE VIS-A-VIS THE NGO'S AND OTHER DONORS IN DEVELOPING AFGHANISTAN'S HEALTH CARE SYSTEM AND QUOTE STRENGTHENING THE CAPACITY END QUOTE OF THE AIG/MOPH AND REGIONAL HEALTH COMMITTEES TO PLAN AND MANAGE AN EXPANDED PYRAMID OF HEALTH SERVICES INSIDE AFGHANISTAN? SHOULD IT MAINTAIN OR ALTER THAT ROLE? HOW CAN THE PVOS BE SUPPORTIVE? WHAT IS THE POTENTIAL FOR COORDINATION WITH OTHER DONORS? WHAT ACTIONS CAN BE TAKEN NOW TO FACILITATE THE SUCCESSFUL MERGER OF THE AIG/MOPH, THE REGIONAL HEALTH COMMITTEES AND THE KABUL GOVERNMENT MOPH?

(B) HAVE MSH, IMC AND IMC DEVELOPED WORKABLE STRATEGIES FOR MOVING THEIR PROGRAMS INSIDE? WHAT IS RECOMMENDED?

(C) WHAT IS THE LIKLIHOOD THAT THE HEALTH ACTIVITIES BEING SUPPORTED THROUGH THE IRC COOPERATIVE AGREEMENT WILL MAKE THE SHIFT INSIDE AFGHANISTAN? HOW SHOULD THESE ACTIVITIES FIT INTO THE OVERALL A.I.D. HEALTH STRATEGY?

- 6. FINANCIAL AFFORDABILITY

(A) EVALUATE THE TRAINING FACILITIES OF EACH ENTITY AND ADVISE HOW THESE MAY BE DOWN-SIZED OR RESTRUCTURED TO REDUCE COSTS WHILE AT THE SAME TIME PRODUCE HIGH QUALITY GRADUATES.

(B) EXAMINE THE PLANS AND PROGRAMS OF IMC, MCI AND MSH AT COST CUTTING - PARTICULARLY IN THE AREAS OF REDUCING PHARMACEUTICALS AND MEDICAL EQUIPMENT SUPPLIED INSIDE - AND THEIR IMPLEMENTATION OF REVENUE GENERATION (FEE-FOR-SERVICE AND CHARGING FOR MEDICINES) EFFORTS. MAKE RECOMMENDATIONS FOR IMPROVEMENT.

(C) ASSESS SALARY LEVELS PAID TO HEALTH WORKERS INSIDE AND NEEDS AND EFFORTS MADE TO STANDARDIZE THESE SALARIES AND ANY OTHER BENEFITS PROVIDED.

- D. METHODS AND PROCEDURES

THE REVIEW TEAM SHOULD ANALYZE KEY DOCUMENTS, INCLUDING: (1) THE 1989/90 PVO AND HSSP EVALUATIONS; (2) THE COOPERATIVE AGREEMENTS BETWEEN O/AID/REP AND MSH, IMC, MCI AND IRC; (3) THE MSH FY 1992 WORKPLAN AND THE IMC AND MCI DRAFT FY 92 PROGRAM PROPOSALS THREE SETS OF THESE DOCUMENTS, EXCLUDING IMC AND MCI'S DRAFT PROPOSALS (WHICH WILL BE AVAILABLE 1/30/92), WILL BE MAILED VIA APO, BY DECEMBER 31 TO ASIA/DR/TR/HPN FOR THE SELECTED EVALUATORS. THESE DOCUMENTS SHOULD BE REVIEWED BY ALL TEAM MEMBERS BEFORE ARRIVAL IN PAKISTAN.

- THE TEAM MUST INTERVIEW ALL KEY O/AID/REP, IMC, IRC, MCI AND MSH EMPLOYEES. THEY MUST ALSO INTERVIEW THE MOPH, REGIONAL HEALTH COMMITTEE REPRESENTATIVES (BASED IN PESHAWAR), RELEVANT NGO'S (BASED IN BOTH PESHAWAR AND QUETTA), AND UN AGENCIES (PARTICULARLY UNICEF AND WHO) TO GET A FULL PICTURE OF THE EXISTING CROSS-BORDER HEALTH PROGRAM. BECAUSE OF THE LENGTHY SOW, THE TEAM LEADER WILL ASSIGN EVALUATION ISSUES/QUESTIONS TO DIFFERENT TEAM MEMBERS; HOWEVER, THE ENTIRE TEAM WILL MEET AT LEAST ONCE EVERY TWO DAYS TO REVIEW THE ENTIRE SCOPE OF THE EVALUATION AND FINDINGS TO DATE. A SIX-DAY WORKWEEK IS AUTHORIZED. ONE DAY WILL BE SPENT IN ISLAMABAD AT THE BEGINNING OF THE EVALUATION PERIOD AND ONE DAY DURING THE THIRD WEEK FOR DEBRIEFING, PRIOR TO THE FINALIZATION OF THE EVALUATION REPORT, WHICH IS REQUIRED BEFORE THE TEAM LEADER'S DEPARTURE. THE TEAM LEADER WILL STAY, WITH PALMER, FOR THE REMAINDER OF THE THIRD WEEK - MOSTLY IN PESHAWAR - TO FINALIZE THE REPORT. THE TEAM LEADER HAS ULTIMATE RESPONSIBILITY FOR COMPLETION OF THE ENTIRE FINAL EVALUATION REPORT. O/AID/REP WILL ATTEMPT TO PROVIDE TRANSPORTATION FOR THE TEAM AND
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SECRETARIAL ASSISTANCE FOR THE FINAL REPORT; HOWEVER THIS MAY NOT BE POSSIBLE AND DOLS 2,000 SHOULD BE BUDGETED FOR IN-PAKISTAN TRANSPORTATION AND REPORT PREPARATION. THE TEAM SHOULD BRING AUXILIARY PORTABLE CALCULATORS, A DICTATING MACHINE AND ONE OR MORE PERSONAL COMPUTER/WORD PROCESSORS TO REDUCE PRESSURE ON O/AID/RFP STAFF AND EQUIPMENT.

F. THE FINAL EVALUATION REPORT WILL INCLUDE DETAILED RESPONSES, INCLUDING RECOMMENDATIONS (WITH CLEAR BASES FOR EACH RECOMMENDATION) FOR EACH OF THE QUESTIONS GIVEN IN THE DETAILED SOW (PARA 2C ABOVE). THE REPORT FORMAT WILL BE AS FOLLOWS.

- -- TABLE OF CONTENTS
- -- EXECUTIVE SUMMARY
- -- BODY OF REPORT - TO FOLLOW SOW OUTLINE IN PARA C, ABOVE, AND/OR AS AMENDED.
- -- RECOMMENDATIONS
- -- APPENDIXES (IF NEEDED)

THE ENTIRE REPORT (EXCLUSIVE OF APPENDIXES) SHOULD NOT EXCEED 30 PAGES.

3. ON A PRIORITY BASIS, PLEASE ADVISE THE O/AID/RFP THE NAMES AND DATES OF AVAILABILITY OF THE EVALUATORS. THE O/AID/RFP WILL PROVIDE FUNDING INFORMATION/DOCUMENTS WHEN FUNDS HAVE BEEN PROVIDED BY AID/W AND WE WILL. PUT TOGETHER THE EVALUATION TEAM'S SCHEDULE AND CABLE THIS NLT 15 DAYS BEFORE TEAM MEMBER'S ETA. PLATT
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APPENDIX B

PERSONS CONTACTED

O/AID/REP

Robert Bakley, AID Representative
Jonathan Sperling, AID Deputy Representative
Nancy Hardy, Program Officer
Curt Wolters, Evaluation Officer
Diana Swain, Project Development Officer
Doug Palmer, Health Development Officer
Mala Georgian, PSC/Health Assistant
Dr. Tom Eighmy, Acting RAO/Peshawar
Zia Mojaddedi, RAO/Quetta

Ministry of Public Health/AIG

Dr. Najibullah Mojaddedi, Minister
Dr. S.M. Amin Fatimi, Deputy Minister and Director General for the Institute of Public Health
Dr. Ghulam. Rabanni Popal, Foreign Relations Officer
Prof. Jalal, Director General for Administration
Dr. Mohammed Tahir Akbari, IPH
Dr. Wahidi, Director, MCH Department
Dr. Nooria, MCHO
Dr. Malalai, MCHO

Management Sciences for Health

Dr. William D. Oldham, Chief of Party
Richard Johnson, Training Advisor
Dr. Laurence Laumonier, Field Operations Advisor
Dr. Paul Ickx, Child Survival and Communicable Diseases Advisor
Linda Tawfik, MCH Advisor
Vim Dias, Procurement and Supply Management Advisor
Mary Gasper, Finance Officer
John Eaton, Health Services Department Advisor
Michael Enright, Health Care Financing Advisor
Mr. Yusef Ghaznavi, Senior Program Specialist
Dr. Mubarrak Shah, Deputy Director, Training Division
Mr. Sabir Latifa, Deputy Director, Health Services Division
Dr. Masud, Training Division
Mr. Karim, Training Division
Assadullah, In-charge of Monitoring
Mahmoud Maksoudi, Monitoring Unit/Editor
Zabiullah, Monitoring Unit/Camera Man

Area Services Health Administration Liaison Officers

Dr. Nik M. Attai, HCCA
Dr. Hamid, HCCA
Dr. Wasiq, SCNA
Dr. Daud, SCNA
Dr. Amir M, SCNA
Dr. Mahmood Shah Darwish, SSWA
Mr. M. Yasin N., SSWA
Dr. Gul M., HCPP
Dr. Mir Ghousuddin, HCPP

International Medical Corps

Dr. Richard Gyory, Director
William Naj, In-country Director
Dr. Anwar, Medical Director

International Rescue Committee

Dr. Randy Martin Director
Andrew Wilder, Coordinator, Rural Assistance Program
Lisa Laumann, Project Officer

United Nations Agencies

Dr. Jan Theunissan, WHO Representative
Mrs. Marianne Geuns, UNICEF
Dr. Alister Lipp, WHO Coordinator, Quetta

Mercy Corps International

Neil Huff, Director
Dr. Imam, Medical Director
Dr. Kho, Medical Advisor
Janice Jespersen, Nurse
Dr. Marikka Purola-Lofstedt, Health Project Advisor

Swedish Committee for Afghanistan

Ghulam Farooq Wordak, Health Department Director

RONCO

Earl Theime, Quetta Representative

APPENDIX C

MAJOR DOCUMENTS REVIEWED

CCAR (Chief Commissionerate For Afghan Refugees), et al.
1991 The Afghan Female Health Worker Manual. Peshawar.

Institute of Public Health (IPH)
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1991 Medical PVO Co-Financing Program. 1991 Annual Report. (Draft)

1991 Quarterly Narrative Report to the Office of the AID Representative/Medical PVO Co-Financing Program. (October 1 - December 31, 1991)

Liwal, Noor Rahman
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Management Sciences For Health (MSH)
1986 Cooperative Agreement dated September 22, 1986.

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APPENDIX D

STATUS OF PROGRESS MADE ON ACTION DECISIONS IN THE PROJECT EVALUATION SUMMARY (PES) OF THE HEALTH SECTOR SUPPORT PROJECT (FEB 5, 1990)

The PES formulated action decisions, progress towards which is reported below.

1. USG should lift travel ban inside Afghanistan by US citizens

-No progress. Security in some parts of Afghanistan has deteriorated. It is unlikely the ban will be lifted until the Embassy and USAID are able to move to Kabul.

2. MSH to hire a senior Afghan coordinator

-An Afghan professional living in the States was hired on a one year contract, part-time basis. His effectiveness in providing information on what Afghan health authorities are thinking and facilitating communication has been marginal, at best. MSH has been able to establish close working relationships by dealing directly with Afghan authorities.

3. MSH to continue active support of Area Health Development Schemes and promote coordination between the schemes, MOPH and PVOs

-Development of the schemes has been supported intensely, and their numbers increased to four. The Institute of Public Health of the MOPH works in support of the activities of the schemes, but there is little other MOPH involvement with them. The PVOs largely have ignored the schemes, and MSH has done little to stimulate the PVOs to do so. The USAID Health Development Officer is increasingly encouraging coordination and cooperation, but with the PVOs, this is nascent.

4. MOPH should train BHWs only for maintenance of 1500-1700 BHWs in the field

-Done. A cap on training of new health workers in all categories supported by USAID was imposed to limit numbers existent on September 30, 1990. The cap level for BHWs is 1355.

5. Experimentation with various hierarchical delivery systems should continue

-Satisfactory ongoing progress. The area schemes are beginning to show some signs of a health system, but should show improvement when Rural Health Officers with management and supervisory skills are introduced after current training. Much of the rest of the donor community views the area schemes with skepticism, feeling they are an MSH invention. None of them,

however, are developing anything similar to contribute to system development. Experience to date with Provincial Medical Officers installed by the MOPH has not been beneficial; there has been unwillingness inside Afghanistan to recognize their authority.

6. Expanded efforts should be made to locate, train and deploy female health workers

-Progress has been made by all USAID-funded entities, but it is slow. MSH, IMC and MCI all employ some female physicians in their clinics. MSH and MCI are undertaking new and expanded approaches to train female Afghan MCH workers which look promising, but it is too early to evaluate.

7. Increase preventive health activities

-Significant progress made. Awareness and understanding of PHC and general preventive measures widespread within entities supported through USAID CAs, and in their workplans and training.

8. reduce the sophistication of pharmaceuticals provided to BHWs

-MSH has conducted a systematic review not only of the supply provided to the BHW, but also of all its medicine. The review was not made in order to reduce sophistication, but to reduce costs of medications for all MSH-assisted activities. The BHW pharmaceutical supply has been reduced both qualitatively and quantitatively. It was found, for example, that multivitamins frequently were being used as very expensive placebos, and this costly item was eliminated. In total, three items were eliminated from those supplied to the BHW, and the quantities reduced on 8 items. Quantities were increased on one item. This process has resulted in significant cost savings to MSH, and as a result of the new combined procurement, it will provide a degree of standardization and cost savings to IMC and MCI as well.

9. MSH should advise and promote the concept of the BHW as appropriate for the base of the Afghan health Pyramid

-No concerted effort made in this behalf. Communication between MSH and PVOs is inadequate and need improvement. PVOs are not yet thinking in system terms, but have free-standing clinics sprinkled around the countryside.

10. MSH will develop and promote the concept of the Rural Health Officer (RHO) within the PVO and donor community

-The first batch of RHOs has been recruited and will finish 9 months training May 31, 1992 and be deployed. The donor community and the PVOs remain skeptical of the RHO since they have not yet begun to seriously consider systems development.

Additionally, they tend to think of the RHO as just one more category of health worker to add to the 30 or so other categories trained outside of Afghanistan. Deployment and demonstration of utility and productivity likely will be necessary before they will consider the RHO concept fairly.

11. Fifteen of 40 RHO positions should be filled by females

-This has not happened for because of the barriers to recruiting women and the revised scope of work for the RHOs. All 20 of the current RHO trainees are male. A new category of health supervisor is the clinic based Maternal Child Health Officer (MCHO) created specifically for females. The first class of trainees should graduate 10 MCHOs in April, 1992.

12. USAID-funded mid-level health workers trained by PVOs should be increasingly deployed to areas with supervision and referral systems in place

-No progress. The cap placed by USAID on numbers of personnel and facilities which USAID would fund has precluded development of new facilities in territories controlled by the Health Committees of the Regional Shuras. Even in those areas, supervisory and referral systems are not yet developed. In a few cases, attrited health workers and/or clinics of the PVOs have been replaced and have moved into geographic areas under the Regional Committees, but have not really linked to the Committees.

13. A working knowledge of PHC should be incorporated in AID/REP supported health PVO training programs

-Considerable progress has been made within all supported CAs. A primary example of this has been the development and beginning use of a curriculum for the Combined Medical Continuing Education Program (CMCEP), heavy with PHC concepts and practice, being used for refresher training for mid-level health workers by all USAID-funded CAs.

14. MSH and the MOPH need to work with the CMC members and WHO on the restructuring of the health worker minimal skills list

-The CMC is defunct. Standardization was accomplished outside of CMC for mid-level health workers, and is underway for lab techs and EPI personnel.

15. MOPH and WHO could provide certification of health workers

-The point of this PES decision was to try to get some legitimacy for the training in Pakistan during the interim period which would enable the future government in post-settlement Kabul to bring these graduates into the civil service without extensive retraining. To date, WHO is certifying all mid-level health workers who successfully complete the newly established refresher

training (the Combined Mid-Level Continuing Education Program, or CMCEP). Although the BHW training at MSH exceeds WHO guidelines, to date there has been no movement to having that training certified.

16. MSH should influence the MOPH and the Regional Health Committees to not develop vertical EPI, TB and malaria programs

-No vertical programs in the usual sense have been developed. Even the most developed program, the EPI, is a series of patchwork efforts undertaken by the various providers, typically as extensions of their curative systems.

17. MSH will not purchase vaccines for the MOPH and Regional EPI programs

-At the time this recommendation was written, it appeared that UNICEF was not going to fulfill its obligations under international agreements. Because of high level US intervention, UNICEF did fulfill the obligations. Currently, UNICEF reportedly is undergoing severe financial strains. As a temporary measure, USAID has agreed to a one-time emergency purchase of vaccines in order not to jeopardize this important program. This agreement came after intense discussions among USAID, UNICEF and MSH.

18. After 1900, MSH will only train EPI technicians for work in areas in Afghanistan which have pyramidal health systems allowing them to train and supervise BHWs to immunize

-Operational realities within Afghanistan have precluded achieving this end. While the majority of MSH vaccinations are occurring within the areas of the Regional Committees, they are not done under the traditional pyramidal structure of supervision. The coverage is being provided by a combination of fixed, outreach and mobile approaches. Mid-levels and BHWs assists the vaccinators, but do not carry on EPI independently. Development of EPI Supervisors was severely interrupted by the evacuation of US personnel during the Gulf Crisis and by the ban on cross-border activities imposed by the AID/REP.

19. MSH should assist in the development of small pilot TB programs

-Three treatment facilities are offering diagnostic and treatment services on an organized, ambulatory basis, adequately backstopped by medical, laboratory and follow-up services. Early results have been impressive.

20. MSH should not get involved in nation-wide malaria control efforts except to support treatment within a PHC system

-MSH has not become involved in such nation-wide control efforts

21. MSH should persuade the MOPH and Regional Committees to utilize training sites where there are active clinics for women and children

-This had been done.

22. MSH should continue to support the "Buddy Care" Training courses for the Majahideen

-Such courses were continued through 1991 but have now been discontinued.

23. USAID should arrange to provide an expert in health care financing to expose the MOPH, Regional Committees and PVOs to this important area

-USAID has provided such an expert for one year assignment which began in December, 1991. He is provided through MSH but has a mandate to work with all the above entities and through the ACBAR Health Committee.

24. The major tasks contained in the MSH Cooperative Agreement will be restated and focused to bring them up-to-date and make them more clear and measurable

-Amendment to the Cooperative Agreement #11-13 signed in March-May, 1991 added much specificity to the MSH Cooperative Agreement. Number 11 dealt, inter alia, with revenue generating activities, cost reduction in pharmaceutical procurement, combining procurement by MSH, MCI and IMC, establishing combined refresher training for mid-level health workers, establishing a cap on numbers of health workers and facilities, and revising the "Major Tasks". Number 12 dealt further with combined procurement, and number 13 with bringing the health finance advisor on board.

25. The O/AID/REP will propose a one year matching grant if CMC members are willing to pay have the expenses and set up an acceptable work agenda

-The Coordination of Medical Committees (CMC) group was an attempt by many of the various donors and PVOs to coordinate health activities. The matching grant was made, but the CMC became defunct because of uninspired leadership and subsequent dropping off of interest and membership.

26. The O/AID/REP will arrange for a thorough inventory of trained Afghan health personnel in the refugee camps and PVO and donor community to permit planning for post-war health care in Afghanistan

-No progress. Because of the labor-intensive nature of this recommendation, the difficulties inherent in tracking these individuals after return to Afghanistan and the likelihood that many of these refugees will not repatriate, no further action will be taken.

27. As possible, MSH will collect information on health care workers trained by the PDPA and by Iran

-No progress. This is a task better left to WHO.